

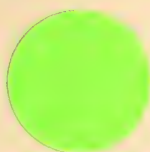
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STATE INNOVATIONS IN HEALTH

MARCH 30, 1980

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Susan Mertes**

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I. INTRODUCTION



Introduction

Rising health care costs continue to command the attention and concern of almost everyone in the United States. Businesses increase the cost of their products to pay for higher health insurance premiums; employers reduce their disposable incomes to pay higher taxes for publicly sponsored health programs; and uninsured individuals live with the fear of a major illness that could bankrupt them. Each of us is affected not only by high medical costs but by relentless inflation in this particular sector of the economy.

These problems have been keenly felt by state governments across the country. As major employers, state governments are greatly concerned about the rapid increase in premiums for hospital care they must pay on behalf of state employees. As a major purchaser of health care for the needy, states continue to face fifteen percent annual increases in their Medicaid budgets — increases which are rapidly drying up scarce resources for other worthwhile health and social services programs. Having responsibility for their states' economic environment, state legislators are concerned about the ability of some businesses to remain competitive and still generate sufficient profits for future capital investment in the face of growing legitimate demands by workers for health benefit increases. And, finally, legislators are worried that unacceptable rates of inflation in hospital costs will rob our nation of the fiscal resources necessary to provide national catastrophic health insurance coverage or perhaps more comprehensive health insurance protection.

During the fall of 1978 the National Conference of State Legislatures sponsored a major national seminar on the theme of "State Innovations in Health Care." While much of the focus at the conference was on methods for containing health care costs, considerable attention was also given to such critical issues as gaps in health care coverage and the geographic and specialty distribution of health manpower. Although it is clear that the federal government has a major role to play with respect to each of the preceding issues, the conference served to demonstrate that several states had already initiated solutions in one form or another to each of those problems. For example, by late 1978, fifteen states had enacted legislation requiring the disclosure, review or regulation of hospital rates or budgets. Moreover, seven states had enacted their own catastrophic or comprehensive health insurance plans. In addition, many more states had established programs designed to alleviate the problems of oversupply of physician specialists and the maldistribution of health professionals.

The problems of inflation in health care costs, gaps in insurance coverage, and maldistribution in health manpower supply will continue to confront both state and federal lawmakers over the next several years. It is critical, therefore, that the policies and experiences of those states that have managed to achieve a measure of success in addressing one or more of those perplexing issues be highlighted for the benefit of other states that may wish to follow. Moreover, it is our hope that

those at the national level responsible for formulating a national health policy will learn from the ongoing variety of experiences that are rapidly developing at the state governmental level.

The effectiveness with which the states manage to resolve some of the more difficult problems of today's health care system — cost, quality and access — is likely to have a significant bearing on the nature and extent of the states' role under a national health insurance program. Last year's seminar from which this publication is a product represented one attempt, among many, to ensure state involvement in the ongoing dialogue and development of a national health care policy.

As the authors of these papers demonstrate, the state level of government can play a crucial role in making the health care system more accessible and more cost effective. This seems to have been true both in the United States and, at the provincial level, in Canada. Innovation, experimentation and responsiveness to local needs are some of the very real assets of a federal system. For instance, many, if not most major federal health policies in the United States claim their roots in previous state and local level experiments and demonstrations.

Most analysts are aware that state governments have at least the *theoretical* capacity for greater experimentation and more local responsiveness than the federal government. At the same time, however, federal policy-makers have been greatly concerned that national policy implemented through the states does not assure that high-quality, cost-effective health services are equally available to all citizens. Massive federal takeovers of state functions are often proposed as a simple solution to resolve these sometimes startling disparities in state performance. In the long run, however, uniform federal control seems certain to stifle the creativity and the responsiveness that have been the genius of the American federal system. Because this publication highlights some of the creativity of the federal system, it is our hope that it will be a

useful manual for state and national legislators, as well as others, who are concerned with improving the adequacy and efficiency of our nation's health care system.

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Editors

National health Insurance: Canada's Path, America's Choices

Theodore R. Marmor and
Edward Tenner

Medical care and national health insurance are major issues in contemporary American politics. The public is uneasy about the costs of illness and the reliability of access to medical services. Congressmen, public officials, and health pressure groups have proposed competing national health insurance plans and have tried to estimate their effects on cost, quality, and access. An informed understanding of other national experiences with governmental health insurance would aid our policy discussion and choice. In particular, Canada's national health insurance program, which resembles some current American proposals, can tell us much about both the impact of a new national health insurance plan on medical care and the reactions of national policy-makers and the public to this impact.

The primary purpose of Canadian hospitalization and physician insurance was to eliminate financial barriers to health care. In this it succeeded. Canada's success in controlling costs to individuals, however, was not matched by achievements in controlling costs to Canadian society. At best, the burden of medical inflation has been shifted from individuals to the government; at worst, national

health insurance itself has had some inflationary effect, though this has been somewhat braked in the last few years.

Similarities and differences

The Canadian national health insurance experience is especially applicable to American proposals because both Canadian society and its health care concerns are strikingly similar to ours. Public officials of both countries worry about the increased proportion of national resources going to medical care and wonder what marginal health improvement it has brought. They also want to assure equal access — financially, geographically, and socially. A vocal minority in each country wants major reorganization of care, including stricter regulation of medical care providers. Finally, after many years of expansion, both Canadians and Americans are trying to reduce the use of expensive hospital services and to stabilize the number of hospital beds, and to a lesser extent, of physicians.

The structure of the health industry and the history of voluntary health insurance in Canada and the United States are strikingly similar. American and Canadian hospitals are largely "voluntary" and not government-owned, and physicians in both are still typically paid under a fee-for-service system. The two countries adjusted similarly to the growth of health insurance, largely private at first, but increasingly more public in character in the postwar period. Although there has been

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universal government medical-hospital insurance in Canada since 1971, hospital insurance was enacted in the late 1950s and medical insurance covering physicians and related services in the mid-1960s. Sequential provincial adoption of the federal cost-sharing between 1966 and 1971 delayed complete implementation of medical insurance until 1971.

Politically, the United States is closer to Canada than to any other nation. Canadian political authority is decentralized and its tradition of dispute over federal power in some ways resembles our own. A major difference between the American and Canadian experiences, however, often put forward as problematic for using Canada as a "most similar system," is the greater constitutional and political independence of the Canadian provincial governments, compared to the American states. Canadian health insurance *had* to be decentralized. If the United States chooses centralized insurance, on the other hand, it may have to rely more on European experience. But the greater the role the United States assigns to decentralized units, the more it can learn from Canadian national standards and provincial cost control (or provincial inability to control costs).

Both the form and content of Canadian health care legislation rest on a constitutional division of powers between the provinces and the federal government which generally reserves health care to provincial jurisdiction. Insurance for both hospital and physician service subsidizes an average of half the cost of provincial programs meeting standards of universality, coverage, and administration. Financial incentives for joining both programs have proved irresistible to all provinces. The federal government share varies inversely with each province's per capita spending on covered medical services, the highest subsidy being about 80 percent.

Administered thus by the provinces with heavy federal subsidy, the Canadian system lacked both the combination of appropriate means and powerful incentives to control inflation. Because of the federal subsidy, the

provinces lacked sufficient incentives, particularly in the early years; because of provincial administration the federal government still lacks the means. Unfortunately, some of the more prominent United States proposals for national health insurance share the Canadian system's failure to concentrate fiscal responsibility at a single level of government. And to the dismay of the provinces, the federal government in Canada proposed, in the 1970s, a new tax-sharing system under which 100 percent of the costs of medical services in the 1980s would be borne by the provinces.

A second major difference between the two countries lies in the divergent routes they have taken to national health insurance. Canadian national insurance began with hospital coverage, followed a decade later by full-scale coverage of physicians' charges. In contrast, the United States has been extending protection gradually to additional segments of the population, first the aged, then the poor, and perhaps in the end to everybody. These historical differences should not, however, deter health care planners from useful comparison.

Whatever the differences, Canada and the United States, having converged at extensive insurance coverage, are facing similar choices in health care and public policy. Two of these choices have been tried less extensively in Canada than in the United States: substantial coinsurance or deductibles, and prepaid group practice. We may learn from Canada's reluctance to try the former or to allow growth in the latter under national health insurance. Canada has been several years ahead of the United States in introducing some measures to control costs and distributing medical care more fairly. Despite the lag, U.S. experiences have had remarkably similar results.

Co-payment and cost control

Canadian and American costs have been strikingly parallel. The trends of prices, utilization, and expenditures are similar and the proportion of national resources spent on health was almost identical up to 1973. Since

1973, medical care expenditures have escalated more rapidly in the United States than in Canada. The late sixties witnessed severe medical inflation in both countries; and while the increase in the relative cost of health care declined somewhat in the early 1970s, in the last two years medical costs have again escalated rapidly.

Some suggest that requiring patients to pay deductibles, or coinsurance, as is more common in the United States, makes them more cost-conscious. Canadian analysts are skeptical. Some modest point-of-service charges to raise revenue or discourage unnecessary use are permitted by the Canadian system, but they have proved so unpopular that only Alberta, British Columbia, and the Northwest Territories now levy them. For most Canadians, national health insurance contains no cost-sharing up to the federally mandated standards. To go beyond the standards of the public program (especially the ward accommodation standard for hospitalization), many Canadians purchase supplementary coverage insurance. Some modest co-payment was tried under Canadian Medicare — in Saskatchewan from 1968 to 1971 — but its effect on total expenditures is unknown. It did, however, reduce utilization by the poor and the old. Since there is little evidence in Canada that co-payment reduced the “least medically necessary” care, it seems needlessly regressive. Certain commentators hold that the patient, after initial consultation, depends on the physician’s judgements, which are not influenced by co-payment. But co-payment *does*, as the Canadian economist R.G. Evans has pointedly said, “reduce program costs by transferring them back to the ill rather than forward to taxpayers,” and it inhibits initial visits more than it does those initiated by physicians. In Canada, he judges, this is “politically highly unpopular, and consequently co-payments as a means of cost-control appears . . . a dead issue.”

Co-payment is clearly not a dead issue in the United States. Indeed, almost all of the current major proposals rely on co-payment

for family health expenditures. American co-payment plans differ from Canadian models in two ways. First, some vary the amounts with family income to reduce the regressive effects of fixed dollar co-payments. But the likely supplementation of national health insurance proposals of either the 1974 CHIP (Comprehensive Health Insurance Program advanced by the Republican administration) or of the Kennedy-Mills type would reduce the out-of-pocket expenditures of the middle and upper income groups buying supplementary insurance. The major effect of co-payment under those plans would be to reduce government program costs. In addition, the distribution of actual cost-sharing with almost certain supplementation by private insurance would be sharply different from that of the formal proposals. Second, American national health plans limit federal program costs sharply by substantial patient cost-sharing and other means. Political figures were reluctant to advocate “new” federal expenditures in 1974-75 even if they had to mislabel mandated non-governmental expenditures as “private health spending.” But paying for the total United States personal health care bill through governmental budgets does not reduce opportunities for other governmental initiatives. And Canadian efforts to contain increases in medical expenditures reflect this problem, too.

Inflation in hospital and physician costs

Since 1948, the National Health Grant Program has financed nationwide hospital expansion. Unlike the construction program advanced in the United States under the Hill-Burton Act, the Canadian plan was specifically intended to prepare the way for national hospital insurance. Canada and the United States proceeded in the postwar period from somewhat different starting points as to number and costs of hospital beds; nevertheless, they have experienced very similar trends. Canada still has more hospital beds per capita and higher rates of hospital admissions,

patient days of care, and expenditures per capita.

Canada has experienced a rapid increase, not in hospital *use*, but in *expenditures* for hospital services. As in the United States, most of this resulted from higher expenses per patient day, not from increased per capita use. From 1953 to 1971, Canadian hospital expenditures per capita (in constant dollars) increased 259 percent while hospital patient days per capita grew by only 29 percent. In turn, most of these higher costs reflected mounting wage bills. Evans estimates that from 1953 to 1971, hospital wages increased 68 percent more than the average wages of all industrial workers; staff hours per patient day increased by 45 percent.

Evans suggests that hospital admission is not very sensitive to price; the reduction in point-of-service costs of care did not lead to a large increase in utilization. If this is so, co-payment requirements for patients will restrain neither use nor costs, and will only redistribute costs to the hospitalized ill. Cost-sharing provisions in a number of current U.S. national health insurance proposals seem questionable on this issue.

Canadian experiences becloud other cost control methods proposed here: detailed budget review, incentive reimbursement schemes with global (as opposed to line) budgeting, and direct bed control. Canada has employed detailed budget review for more than a decade, and while it is apparently a good instrument for detecting fraud, it has failed to check expenditures. Some provinces have partially replaced it with global budgets and reimbursement policies. Their experience suggests that there are serious limitations to plausible reimbursement schemes. Some American authorities, like Judy and Lester Lave in their book, *The Hospital Construction Act*, advocate reform of reimbursement "so that hospitals are no longer guaranteed that revenues will equal costs regardless of their productivity." The authors recommend an "incentive reimbursement system" on a case basis using a formula "that assured the hospi-

tal of operating and capital costs. Deficits would force inefficient hospitals to improve their management, change the nature of their operations, or shut down."

Our Canadian interpreters provide evidence that such a system, however appealing theoretically, is difficult to implement. For political reasons, poorly managed hospitals are rarely allowed to fail; capital funds are supplied separately from operating budgets; case mix adjustments are not well worked out; and hospital managers do not seek "profits" as strongly as they do improved services — and thereby larger budgets. The Canadian turn from fine-tuned management incentives to supply constraints is revealing. So is the questionable effectiveness of "hospital substitute" strategy — the use of very broad benefits to discourage expensive treatment like hospitalization in cases where nursing homes or outpatient clinics would save money. Yet, according to Evans, "unless new facilities are balanced with withdrawal of the old, total costs rise." In the United States, Martin Feldstein found that extended-care facilities raise the cost per hospital episode. What is saved in shorter acute-care stays is lost in longer extended-care stays.

The weakness of line-by-line and global budget techniques and substitutes for hospitalization as devices to control Canadian inflation provides a demonstration lesson for the United States. Short of direct government control over wages, there are few policy alternatives to bed control which can actually check hospital expenditures.

National health insurance and physicians' incomes

Canadian experience with medical insurance is strikingly relevant to the American health care debate in three other important respects: complaints about the fees and incomes of physicians; about the inflationary impact of their practices; and about their maldistribution by location and specialty. One strategy that has been advanced in the United States — and

embodied in several national health insurance bills — is detailed specification of fees and peer review of the appropriateness of both the pattern and the price of care.

Canadian data on the fees and incomes of physicians raise issues of interest to the United States. At about the time medical insurance was introduced, Canadian physicians' fees started to decline sharply relative to other prices. During the same time period, however, real income of Canadian physicians increased. This paradox was built into physician reimbursement under Canadian national health insurance. Canada provided reimbursement at some 90 percent of established fees, but underestimated the amount of bad debts and the variation in actual fees that had prevailed before the institution of national health insurance.

According to Evans, "the single most prominent influence of health insurance in Canada has been to increase the earnings of health providers." The average increase in net physician income (deflated by the Canadian Consumer Price Index) was more than twice as great during the transition to national health insurance as it was in the immediately previous period.

Studies in Quebec show absolutely no increase in the number of physician visits per capita after Medicare. While comparable data are not available for other provinces, there is no reason to expect substantial differences. Thus it does not appear that the increase in physician income can be attributed to increased workloads.

Under national health insurance, Canadian fee-for-service reimbursement has raised physician incomes in two main ways. The first, and the simpler, is the reduction of bad debts and collection expenses. The second is the leveling-up of fees, which physicians have traditionally varied somewhat according to patients' income and insurance coverage. Under national health insurance they try to establish their highest rates as "customary," even though those rates are not necessarily the average fee received or even the fee most frequently asked. If national

health insurance reimburses at the highest rate, net earnings will increase and, just as with bad debt reduction, will not show up as official fee increases.

Clearly average fees received, not so-called customary charges, should be the appropriate standard. But that standard requires detailed information on the actual fees of physicians analyzed by specialty and region. Such information is not easily available in the United States.

Further, bitter controversies in British Columbia, Ontario, Quebec, and other provinces suggest that physician incomes will be a continuous public issue, not simply a matter between the profession and the government. All American discussants are prepared for controversy over the level of fees in a national health insurance program and over variations in fees by education or location — but not over adjustment of fees for removal of bad debts, or over fee reductions.

Professional review of the patterns of service — "peer review" — is already a heated issue among American physicians; Canadian concern about patterns of costly services which do not show up in extra billing but do show up in extra servicing, is parallel. Canadian experience suggests that claims review can weed out egregious cases of excessive and inappropriate claims, but cannot control the fee-for-service system's tendency toward increased units of care. Paradoxically, insistence on fee-for-service payment in societies like Canada and the United States actually threatens professional independence because it implies governmental review. Brian Abel-Smith says, in the July 1974 issue of *Social Security Bulletin*, "World experience has shown, as the United States experience is also beginning to show, the paradox underlying attempts to preserve the free and independent practice of medicine. At first sight, fee-for-service payment enables private free-market medicine to be readily combined with health insurance. In practice, it is not long before interference with medical practice becomes much greater than occurs or needs to occur

when physicians are salaried employees in government service. Physicians are made answerable for each of their acts. Because there are incentives for abuse, restrictive and punitive safeguards are established to prevent abuse from occurring. Sometimes the punishment falls on the physicians, but sometimes it falls on the patient."

Nevertheless, Canadian experience suggests for the United States that this mode of payment will predominate in the post-national health insurance world. A less punitive, more equitable form of fee-for-service regulation, not a shift to salary or capitation, is our own real need.

Access to care

Some Americans believe in training more physicians to improve their geographical distribution and to increase fee competition. But this strategy has largely failed in Canada. And, to the extent that physicians determine the use of other medical care services, it may be inflationary. What would seem to be the common sense view — that increasing the supply of physicians will either significantly improve their distribution or lower their price — is challenged now by a number of Canadian commentators, and the national government fears that a saturation point for certain specialties is near or has been reached in some provinces. More physicians are practicing in under-doctored areas, but dramatic increases in the number of physicians apparently do not keep fees down. Competition had been weakened even before national health insurance by patients' inability to question the prices or qualities of services provided, and their coverage by widespread private insurance. It may well be, as Evans has said, that the role of "national health insurance [in Canada has] been to relax further any market constraints on how physicians manipulate utilization to generate income."

British Columbia, with more physicians per thousand residents than other provinces, has, it is true, among the lowest physician incomes

— but it also has among the highest fees. Increasing physician supply apparently is an expensive and ineffective way to control costs and improve access.

Americans hope that the lowering of financial barriers will distribute access to care much more fairly than our present arrangements do, promoting more nearly equal medical attention to those of different races, incomes, locations, ages, and connections with physicians. The Canadian experience offers mixed results.

First, on the basis of Canada's experience, we should expect relatively modest changes in the overall utilization of hospitals and physicians. The fears that "cheap" care will foster runaway utilization thus appear unrealistic; they ignore the impact of pre-existent health insurance, the barriers to care which financing will not change, and the rationing which doctors will impose. The Canadian experiment contradicts projections of sharply increased use (or crowded offices) based on estimates of the elasticity of demand for medical care in the United States.

Canadian success in redistributing access depends very much on initial expectations. The evidence suggests that national health insurance redistributed access moderately from "rich" to "poor." The R.G. Beck study of Saskatchewan, measuring access by the proportion of nonusers of medical care services by income class, found that nonuse by the lowest income class declined substantially, while nonuse by other income classes remained stable. The P.E. Enterline et al. study in Quebec shows not only an increase in the use of physician care by income groups under \$5,000, but a decline in physician visits for income groups above \$9,000.

More medical care personnel are now available in poorer regions. Maurice LeClair reports that in Newfoundland the supply of medical practitioners in relation to population increased between 20 percent and 30 percent in the first three years of the Medicare program. But there is no evidence that such redistribution took place everywhere, nor that national health insurance eradicated differences in

access by income class. Disparities in access still remain.

Redistribution of care to the less advantaged is still significant. Karen Davis has argued that equal entitlement to Medicare program benefits has unequal results, with greater benefits for the higher-income aged, and that income-conditioned programs like Medicaid only partially redress the balance. The significant cost-sharing of Medicare in the United States is probably responsible for this pattern, the implications of which Davis does not sufficiently take into account. America's better-off aged, less deterred by cost-sharing, use more expensive services, and buy more supplementary insurance for deductibles and co-insurance. If this is the case, and if Medicaid reduces those out-of-pocket expenditures for the poorest, one should expect that the poorest and the richest would use disproportionately larger shares of the Medicare budget. But Canadian national health insurance suggests that where out-of-pocket costs are trivial, equal benefits are associated with increasing access for the disadvantaged.

One should distinguish, too, between equal *use* according to income class, region, and sex and equal *access* measured by the likelihood of identical medical responses to similar health conditions. Canada has not, it appears, achieved equal use; in contrast, Medicaid is ensuring that poor Americans (those with incomes under \$3,000 a year) see doctors as often as or more often than their compatriots. But the likelihood of care for a given symptom still varies markedly with class and income. Canada suggests, then, that national health insurance helps equalize access, but does not completely succeed.

The issue of access leads to another distinction now recognized in Canada—that between health services and medical services. The 1974 Canadian government book, *A New Perspective on the Health of Canadians*, emphasizes that Canadians cannot expect more medical care to make them much healthier. In the United States this argument is raised against national health insurance itself. In Canada it

arises from the removal of much inequity and anxiety by national health insurance. The arguments for national health insurance are more financial and ethical than strictly medical. Canadians take for granted now that illness no longer threatens destitution.

Once that fear is abolished in the United States, and the noneconomic features of access are recognized, American leaders too may well turn to environmental factors for what a group of Canadian leaders recognized as the "key to better national health and reduced rates of increases in health costs."

Postscript

The claims and implications of this article rest on published Canadian time series data for the period 1953 to 1971. For most of the purposes of American public policy, this is ample for cross-national lessons. But unpublished Canadian data do indicate some significant divergence in U.S.-Canadian expenditure patterns in the period 1971 to 1976. To put it in broad terms, the Canadians spent a lower share of their GNP on health in 1976 than in 1971 (roughly 7.1 percent as against 7.3 percent), while the United States spent approximately 8.6 percent of GNP in 1976, as opposed to 7.6 percent in 1971.

Part of the reason clearly has been the general performance of the U.S. economy: a recession produces a lower GNP denominator in the measure. But preliminary evidence from Canada (the Canadian Minister of Health and Welfare is preparing these more recent data for publication) suggests that the rate of increase in real health expenditures per capita did in fact decrease between 1971 and 1976.

II. COST CONTAINMENT: VARIATIONS ON A THEME



Cost Containment

With the cost of health care a major concern of both the federal and state governments, several cost containing strategies are being implemented. The forms of these strategies vary; they include reimbursement limitations, state-level commissions for overall industry cost review, and restrictions on cost-generating capital expenditure projects.

Providing the federal perspective from the Medicaid Bureau Office of the Health Care Financing Administration (HCFA), Medicaid Director Richard Heim reviews specific mechanisms designed to assist state endeavors in controlling health care costs. Heim, who is now HCFA's Director of Intergovernmental Relations, details four federal projects: the Medicaid Quality Control Program identifying third-party liability; the Medicaid Management Information System providing a data base for various uses; State Assessments resulting in an evaluation report of the state program; and the Corrective Action Project directing technical expertise from one state to another.

These federal initiatives to help states control their program expenditures, Heim explains, were begun not only to improve state Medicaid programs, but also in recognition of priorities other than health care that must be attended to by the states. Because of these financial constraints, it is imperative that both the states and the federal government know what they are getting for their health care dollar. Heim urges states to quantify the results of their health care expenditures in order to obtain the necessary data for future

decision making. Accountability for expenditures is a responsibility of the states that must be recognized, he adds.

As a former director of a state Medicaid program, Heim expresses particular concern regarding large Medicaid expenditures for nursing home care: almost 40 cents of every Medicaid dollar is spent on nursing home care, despite the fact that nursing home patients constitute less than eight percent of total Medicaid beneficiaries. He reports that 17 states spend more than 50 percent of their Medicaid dollars on institutionalized long-term care, with three states spending more than 60 percent. Suspecting inappropriate utilization of long-term care facilities, Heim urges states to focus more effort toward identifying and financing practical alternatives to nursing home care.

Federal concern about rising health care costs within this period of financial limitations is not unique to the United States. Canada as well is burdened with similar difficulties. And just as the United States exerts leverage with the states through its Medicare/Medicaid reimbursement mechanisms, so too the Canadian federal government influences the provincial systems through its national medical and hospital insurance plans.

Because of limited financial resources, the Canadian federal government changed its formula for determining federal and provincial shares in financing the nationalized health care system. Douglas Weir, chairman of the British Columbia Medical Services Commis-

sion, explains how the new limitation on federal dollars spurred the provinces to initiate more of their own cost-containing strategies.

"One of the advantages to the provinces of the new cost sharing arrangements is the greatly increased flexibility which it allows. The previous funding was tied to, and could only be used for, costs of acute hospitals and physician services. . . . Under the new arrangement, no strings are attached to the federal funds and there is therefore the incentive, because of the 'closed-end' nature of the funds, for the provinces to opt for less costly alternatives in delivery of health care."

Among the British Columbia programs aimed at greater cost efficiency, Weir describes an extended care and long-term care program that is alleviating some of the acute-care hospital patient load. Day-care surgery, for example, now accounts for almost 30 percent of surgical procedures. An early discharge, home-care program better utilizes the public health nursing service, and is reducing the lengths of stays for surgical and medical patients. Remaining problems encountered by the province seem to center mainly on staying abreast of new technological developments in such ways as determining appropriate fee schedules for tests and restricting the proliferation of inflationary technology.

Weir cautions, however, that the Canadian experience in successfully restraining the rate of health care cost inflation may be due to its anti-inflation board wage controls which were in effect until 1979. He assumes that wage controls retarded the rate of inflation and had a large effect on the labor-intensive health care field.

Other mechanisms designed to impede the rate of cost inflation are state hospital review commissions. Existing hospital review commissions vary widely as to legislative mandate, sanctions and leverage within the health care industry.

The Washington State Hospital Review Commission conducts extensive budget review and exerts considerable influence over various provider groups. Commission Chairman

Ludwig Lobe points out that the Washington Commission was patterned after the potent Maryland Health Services Cost Review Commission, and that both states have registered low rates of hospital cost increases as a result of their efforts.

As mandated by its enabling legislation, the Commission instituted uniform accounting, reporting and budgeting systems; a system for grouping like hospitals; budget rate-review and screening; and year-end compliance criteria. To properly measure and compare hospital productivity, the Commission is developing a uniform unit of measurement for all services, equipment and supplies. Lobe maintains that only through use of uniform accounting, costing, measuring and reporting systems can a useful productivity factor be determined. In addition, the Commission also is involved in an experimental prospective budget review program where all third-party payers (including Medicare) adhere to Commission-set rates.

Although the Commission is empowered to set fees and charges, Lobe points out that it influences hospital costs, fees and charges by examining hospital rates. The Commission defines rates as the total requirements of a hospital revenue center divided by the number of procedures. The Commission acts on each budget for each hospital revenue center and approves an allowable rate for each unit of service for each revenue center. Cross-subsidization among revenue centers, Lobe adds, is allowed only where necessary for community service.

Lobe finds that the Commission-mandated review of newly available technology — conducted by providers and planners to determine if real community need exists — forces a focus on productivity. And it is only through increased productivity, he maintains, that the health care industry can ameliorate unavoidable cost increases.

Lobe strongly believes that decisions concerning "affordable" health care services are best done on the state level rather than the federal level. Fully expecting that future health care standards will be based on limited finan-

cial resources, Lobe expresses greater trust in local decisionmakers for accurately reflecting local needs and acceptable allocation of resources.

Another vehicle designed to control inflationary cost increases on the state level is the certificate-of-need (CON) process, intended to review capital expenditure projects proposed by providers that would result in inflationary cost increases. Wisconsin State Representative Joseph Czerwinski describes his state's CON process as unusually flexible, allowing the state a broader response range to proposed projects than merely "approve-disapprove." In this way, he says, the state's bargaining position with providers and third-party payers is increased considerably.

Czerwinski details how the Wisconsin procedure is more stringent — and, he states, more effective — than the CON regulations found in most other states. Not only does the Wisconsin certificate-of-need process encompass clinics and physicians' offices for certain expensive equipment, but it also provides strict sanctions for applicants who fail to obtain state approval for the expenditure, yet proceed with the project anyway.

Moreover, the state has the latitude to confer conditional certificate-of-need approval (subject to specific conditions) or approval of part of a proposed project.

Enhancing the state's certificate-of-need leverage is its authority to decertify specific hospital special care units that fail to meet criteria for financial viability and are clearly not needed by the community. As described by Czerwinski, "The specialty decertification provision, in particular, is an innovative step which allows the state to influence existing services as well as future capital expenses." Under the law, the state is empowered with decertification authority for the facilities, equipment and staff necessary for the following specialized services: heart catheterization studies or cardiac surgery; radiation therapy treatment of cancer and other diseases; hemodialysis treatment of acute or chronic renal insufficiency; kidney transplants; the intensive

care and management of high-risk maternal, fetal or neonatal patients; and computed tomography.

The Wisconsin state legislator emphasizes that the financial viability of the special care unit in question is heavily weighted in decisions to decertify. An accounting system that directly identifies the revenues and expenses of the special care unit under consideration is used to determine financial viability. In Czerwinski's evaluation, the hospital service decertification program "is as important as certificate-of-need" to control revenues, expenditures, and ultimately, overall costs.

A further advantage of Wisconsin's regulatory program, according to Czerwinski, is that all the state's major health care cost-control mechanisms are gathered under one administrative unit. The state Division of Health in Wisconsin administers CON, the Medical Education Review Committee, Hospital Rate Review, and the Medicaid Management Information System.

Medicaid Reform: The View from HEW

*Richard Heim, Associate Administrator
Medicaid Bureau
Health Care Financing Administration
HEW*

As a former executive director of a state Department of Health and Social Services, I can speak from first-hand experience of the difficult choices state officials are being asked to make between competing social and economic priorities. I sincerely hope that my discussion and this meeting will give you a better understanding of some real opportunities to contain health care costs within your own state, and thereby have more money to spend on other priorities.

After all the discussion you have heard at this conference, I am sure that it will come as no surprise to you to learn that, based on present trends, the country will spend nearly \$310 billion — or about a third of a trillion dollars — on health care by 1983. What are we — and I mean the states as well as the federal government — getting for all this money?

In point of fact:

- Are not the bulk of our expenditures for the treatment of the ill, rather than for the care of the healthy?
- Should we not be establishing in some quantifiable manner what effects the medical procedures and treatment regimens for which we are paying are having on the morbidity and mortality of our population?

Richard Heim now serves as Director, Intergovernmental Relations, Health Care Financing Administration, HEW.

- In truth, do we even know what constitutes quality of care?

Specific HEW Steps

With regard to some specific activities being undertaken by HEW, Secretary Califano announced several months ago a number of initiatives that HEW *would* take — and states *could* take — to control the precipitous, and corrosive, rise in health care costs. These include:

- Development of regulations to limit Medicare payments for laboratory tests and for medical equipment to the lowest price that is widely available for the same quality in a particular community, instead of paying on the basis of average charges or even higher ones.
- Introduction into Medicare of new and tighter computer-screening techniques, like those used by the IRS, to flag health care services that should be audited to determine if they are medically necessary.
- Work with PSROs to set specific goals for lengths of stays and use of tests in order to reduce excessive hospitalization and unnecessary procedures. In my opinion, the most telling effect of PSROs may be in terms of increased quality rather than substantial dollar savings.
- Acceleration of our plans to implement our "Second Opinion" Program which is de-

signed to reduce the amount of unnecessary surgery performed in this country. And,

- Revision of current Medicare regulations to encourage non-profit hospitals to pool their resources and to share services, from laundry and billing services to basic medical programs.

In addition, the Secretary has also written to the Governors of each of the states and territories to request that they work together with their respective legislatures to:

- **Take all necessary action** to promote the substitution of generic prescription drugs for more expensive brand name drugs, both in the Medicaid program and more generally. The Food and Drug Administration will provide technical assistance in this area to any state that desires it.
- **Stimulate the development of health maintenance organizations** and encourage enrollment in HMOs by state employees and Medicaid beneficiaries. And,
- **Support health planning activities** designed to curb construction of unneeded health care facilities that lead to surplus hospital beds and equipment.

Medicaid and Cost Containment

Now let me turn to a subject which is particularly close to my heart: the Medicaid program.

Medicaid today covers nearly 23 million Americans. It involves half of the 17,000 convalescent facilities in the country, as well as half of the 7,000 hospitals. Seventy percent of all pharmacies, and 40 percent of the 250,000 practicing physicians, also participate in our program.

In terms of dollars, Medicaid is bigger than either General Motors or ITT. This year we will spend \$18 billion, and next year we will spend close to \$20 billion. Twenty billion dollars — that works out to \$50 million a day that will be paid out through the program.

What have we gotten in return for all this money? Three major achievements for which

the program is at least partially responsible include: reduction of infant mortality rates among the poor from 75 to 35 per 1,000 over the last 10 years; a 40 percent increase in the number of physician visits by the medically indigent from 2½ visits per year several years ago to nearly 4 per year today; and an overall feeling in the country that things are getting better not worse, and that states themselves are playing an important role in the determination of benefits for the Medicaid system.

While it would be presumptuous for the Medicaid program to take all the credit, I do believe we are having a very beneficial effect on the health care status of this country.

As I said, in fiscal 1978, we will spend approximately \$20 billion to purchase care for more than 23 million people. Of this amount, states will contribute over \$8 billion. Because of the vast amount of money involved, we have undertaken a broad array of initiatives to reduce costs and increase efficiency.

The Medicaid Bureau has four specific programs designed to help states get a better handle on their own health care program costs.

The *Medicaid Quality Control Program* (MQC) is our primary effort to detect errors within our system. Initially, it was a major part of the AFDC Cash Assistance Program in the early 1970's, and Medicaid has now expanded the QC program to detect errors in beneficiary eligibility for all state programs.

We are very pleased with the results of this program and are beginning to expand it. One particularly fruitful area that we are anxious to have MQC expand into is the virgin territory of third-party liability. Medicaid is supposed to be the payor of last resort — only after all other payment sources have been tapped are the state and federal funds in the Medicaid program supposed to be called upon. Unfortunately, we have found that this has not always been the case. The Medicaid Quality Control Program is helping us detect these errors and beginning to save us — both federal and state governments — considerable amounts of money.

A second initiative we have undertaken to control costs is the *Medicaid Management Information System* (MMIS), which helps us improve our control over claims processing errors. But it is much more than that: MMIS provides a broad data base for statistical analysis of past trends, present circumstances and future possibilities.

As one of the first state Medicaid directors with a certified MMIS program, I can testify to its usefulness. Even the U.S. Congress is beginning to see its usefulness. Originally authorized to match states on a 50-50 basis, HEW has recently been authorized by Congress to offer a considerably higher match of 90-10 for development costs of a state's MMIS and 75-25 for operating costs once a program is up and running. The states are taking us up on our offer: when I came on board last April, 15 states had a certified MMIS program. Today 19 are currently certified and 3 more are in the final stages. By the close of this year, we plan on having 25 systems up and running.

A third very productive initiative we are undertaking with the help of HEW Regional Offices is *State Assessments*, offering assistance to the states. After carefully reviewing existing material for information about how well the state's Medicaid program is doing, we send eight to fifteen people into a state for an intense two-week period. We are working to coordinate our efforts with other review activities, such as fraud and abuse, to make the best use of everyone's time.

The end product of this effort is appreciable. A report is issued which gives state legislators and the public a snapshot picture of their own state system — what it's doing right, who it serves, and what possible opportunities for improvement exist.

A fourth initiative is CAP, the *Corrective Action Project*, to provide real technical expertise to states requesting help from the central office. CAP is composed of people who have had direct, hands-on experience in the field, and who now seek to transfer what they have learned from one state program to

another. The Corrective Action Project takes the useful knowledge from one state and injects CAP personnel's own expertise to make it even better.

Nursing Home Industry and Medicaid

I would like to address one particular aspect of health care costs that has me particularly worried: the nursing home industry. We are all aware that the number of people over 65 years of age in this country is growing rapidly. And while their numbers are growing geometrically, the cost of affording institutionalized care for them is growing exponentially.

In Medicaid, for example, nearly 40 cents out of every Medicaid dollar goes toward institutionalized nursing home care. That is an alarmingly high amount, particularly when nursing home patients make up less than eight percent of the Medicaid beneficiaries. But what is even more alarming is that while the proportion of people using nursing homes in our program rose by six percent between 1973 and 1977, total expenditures for institutionalized long-term care increased by 113 percent.

I believe that the real tragedy of America's health care system is that many long-term care patients are in sub-standard facilities because it is more convenient for society to get them out of the way. Many studies by state Medicaid agencies reveal that a significant number of residents in LTC facilities are there not for medical but for social reasons. Many of them require some assistance in daily living that could be provided in a non-institutionalized setting.

Yet we have not been sufficiently imaginative to find and finance practical alternatives to the "either - or" situation of inadequate or absent care in an elderly person's own home or the depersonalized (and frequently dehumanizing) setting of a long-term care institution. While I can only discuss this issue in the context of the Medicaid program, *you* have the responsibility for looking at all the forces that are impacting your state's rising health care bill.

I ask you to look very carefully at how you are spending your health care dollars. The Medicaid program is an open-ended, state-federal program in which the states establish their own priorities. The federal government then matches state dollars. Looking at the nursing home example, again, 17 states devote more than one-half of their Medicaid dollars to institutionalized long-term care. Alaska, South Dakota and Minnesota spend more than 60 percent. Now I recognize that the Medicaid program is just for health care alone, but is institutionalized long-term care where we want to be spending so much of our health care dollars?

I am in no position to judge, but you state legislators must wrestle with these questions, confront the issues, and set your priorities.

I submit that there are a whole host of less expensive alternatives that are just as effective as institutionalized care: home health services, senior citizen activity centers, voluntary programs, etc. No one alternative has all the answers, but we must turn our thinking from traditional — and costly — modes of care to other possibilities, while including the needs of those who currently require institutionalized care.

Lastly, I urge you to seek more information and assistance if you think your state could benefit from it. We at the Medicaid Bureau stand ready to help you. Let's do what we can, let's work together on the problems of *real* money.

The Washington State Initiative in Hospital Cost Containment

*Ludwig Lobe, Chairman
Washington State Hospital Commission*

In 1978, hospital revenues in Washington State are projected to increase by 9.8 percent versus 12.2 percent in the Nation — excluding volume adjustments due to population growth. The projected average rate of cost increase per admission in 1978 over 1977 will be 5 percent in Washington versus 10 to 12 percent in the Nation; the cost per average patient-day will be 5 percent versus 9.6 percent in the United States. Between 1976-1978, the rate of increase in costs per admission for Washington will be 21.3 percent against 24.5 percent nationally; the rate of increase in costs per patient-day during that same period will be 18.3 percent versus 25.1 percent nationally. These costs include both inpatient and outpatient care in Washington State, whereas percentages computed for the Nation as a whole seem to be for inpatient care only (and are not consistent at that).

There are various reasons for the difference in Washington's performance compared to the rest of the Nation. They include:

- A uniform accounting and reporting system;
- A prospective budget review system;
- A cooperative attitude by hospitals;
- A short length of stay;
- Concerned providers, including physicians; and
- An independent Commission of interested citizen members.

Toward the end of the 1960's, the Washington State Legislature Senate Committee on Social and Health Services, chaired by Sen. William Day, began to review and survey hospital costs, with results published in the 1970 overview report. Thereafter, the appropriate legislative committees enacted legislation designed to help contain health care costs. Patterned after the Maryland example, the final legislation was endorsed by the executive and legislative branches of the state government, the state hospital association, labor, and health planning agencies.

Established in 1973, the Washington State Hospital Commission is an independent state agency charged "with the implementation of an effective cost control program that will enable and motivate hospitals to control their spiraling costs without sacrifice of quality of service." The Commission also is empowered to assure all purchasers of hospital health care "that total hospital costs are reasonably related to total services, and that rates are set equitably among all purchasers without undue discrimination."

To fulfill its statutory mandate, the Commission has implemented a uniform accounting, reporting and budgeting system; a system for grouping of hospitals; a budget rate review and screening process; year-end compliance criteria; and conducted surveys and studies, with publication of results.

The Commission encourages hospital management teams, trustees and administrators to

develop their own cost containment programs founded on requisite detailed reporting forms. This reporting system, based on flexible functional accounting principles, highlights excessive costs and reasons for cost increases.

The statements by each hospital include goals and objectives; action plans by cost and revenue centers; operational and contractual arrangements; statistics of service units and direct expenses by centers; step-down allocation method; detail and summaries of budgeted revenues and expenses; cash flow and budget projections for operations; capital expenditures; and sinking funds for depreciation.

Classification of hospitals is based not only on the number of beds, but also includes such factors as case, staff, physician, and service mixes; area population and its financial potential; differences in locations, organizations and resources of providers; plant condition; governmental and other subsidies; and reimbursements.

In reviewing budget and rate requests, the Commission uses an "exception review" process to identify potentially high-cost operations that are subjected to a more thorough review than apparently low-cost budgets would require. Furthermore, each hospital's budgeted expenses are compared to its own peer group classification. Some field audits are being used to confirm the submitted data.

Rate Determination

The Commission has the power to set fees and charges but, at this time, uses this power only in certain cases. Instead, the Commission uses a rate concept to control costs, fees and charges. A rate is defined as the total revenue requirements of a revenue center divided by the number of procedures.

Reasonableness is the standard applied in screening rate requests through peer group medians, historical trends, and industry standards. Expenses exceeding the peer group median are reviewed in further detail by staff. In all, the budget screening process, using

more than 150 variables, evaluates both aggregate expenses and 13 selected expense centers.

The staff review compares revenues to expenses by revenue centers to identify the degree of cross-subsidy. This is determined to assure a reasonable relationship between the costs and charges per unit of service. We expect a divergence ratio of not more than 3 to 5 percent.

To meet each hospital's true financial requirements when setting rates, the Commission also includes an allowance for contractual adjustments (Medicare, etc.), bad debts and charitable services. In addition, the Commission allows a planned capital and service component for justifiable and needed replacement and expansion, additional working capital, and feasibility studies. The Commission believes that future development plans, which are in line with those of community or regional planning agencies' need-determinations (CON), should be considered in prospective budgets as a positive incentive.

There is no provision in the law to grant "profit" or "surplus" to hospitals but, as far as investor-owned hospitals are concerned, the law does allow a fair return to stockholders' investment.

After the staff review, its findings and recommendations are submitted to the Commission members and the hospital under review. The hospital may object, suggest or accept. A review is conducted during an informal public hearing with the Commission members, state hospital association and other interested persons participating.

After the hearing, a "Decision and Order" is issued detailing the actions on each budget and rate request for each unit of service in each revenue center. If the hospital disagrees, a formal hearing is held. The rates set by the Commission cannot be changed unless the Commission allows such change, or legal action is taken. At any time during the budget year the hospital may ask for reconsideration for cause or for amendments. A year-end compliance review shows actual revenues and necessary adjustments for the coming years'

budgets due to unexplained variances. The Commission has enforcement and subpoena powers, but has not had to use them, nor have any formal hearings been requested.

Mutual cooperation and trust among hospitals, the various organizations and the Commission has helped in developing our system and working arrangement.

While the system adequately addresses the expense side of the hospital cost equation, the problem of different reimbursement levels set by various third-party payers remains. The usual retrospective cost reimbursement is counter-productive to the cost containment policies prescribed by the Commission. It encourages the delivery of more service units to more people, necessitating a longer hospital stay and, therefore, a more rapid rise in costs in the health care industry than in other fields. To find a solution, we are implementing an experimental prospective reimbursement program in conjunction with HEW. This is a prospective system in which payments by contract third-party payers are determined by an apportionment of each hospital's total budget and acceptance of Commission-set rates by all federal, state and participating insurance companies.

The various factors considered by the Commission when determining rates are important: some are independent from management influences, such as locale, taxes, utilities, and use by physician or patient; some are subject to the hospital management's influences, such as interest, depreciation, staff size, room and bed size, and service mix; and some are only partly subject to management decisions, such as cost of salaries and wages, supplies and equipment. The utilization factor is, therefore, one of the points at issue.

Under-utilization adds to hospitals' costs just as over-utilization adds to revenue. Both have to be limited whenever possible in the interest of cost containment. The utilization factor demands the avoidance of duplication of services and equipment, especially when there is more than one hospital within reasonable reach of the public.

Productivity Measurement

No doubt, technological progress and new medical and other scientific discoveries and procedures will raise costs. The question arises: To what extent can these higher costs be absorbed or ameliorated by increased productivity of manpower and equipment, and by shared and merged facilities? Productivity of staff — physicians, nurses, or others working in a hospital — is based on the appropriate level of care rendered by well-trained personnel working in a staffing order which gives maximum service at the most economical cost with efficient use of time and staff.

Efforts are underway to develop a uniform, comparative unit of measure for all services, equipment, supplies and whatever else goes into costs, because only a uniform accounting, costing, measuring and reporting system can bring about a weighing of productivity factors that are controllable, not so much by government as by management, consumers and providers.

Because productivity and utilization influence financial viability and cost containment, the Commission reached an early agreement with the state Department of Social and Health Services whereby the Commission reviews the financial and economic feasibility of any new hospital facility, equipment or service costing \$100,000 or more.

Other Cost Contributors

In addition to the factors I have noted as raising the costs to patients, there are others, such as bad debts, charity care, discounts and differences in payments made by governmental agencies and by insurance carriers as reimbursement for the same services.

The true client of a hospital is the one who pays the bill directly, or indirectly via third-party payers, not the physician. Because the payment for services is limited to the amounts available, the availability of funds should replace the wishes of the physician. Physicians' requests for equipment, supplies and

services must be subjected to the same cost effectiveness and benefit analysis as all other requests made to the hospital administration.

Physicians, whether hospital based or under contract, are part of the hospital's responsibility. When a physician is under contract, the hospital should enforce all rates concerning his services. Since the hospital has been held responsible in malpractice suits for acts of a physician, may it not also be logical that it should have the right to supervise professional rates and fees earned within the hospital service structure (especially those who have monopoly status in the hospital service complex)? The possibility of drawing all professionals into cost containment mechanisms becomes more pronounced the faster their fees rise.

Other contracts are of equal importance to the economics of hospitals and patient-consumers. Management must keep in mind that it is in a trust position with the public and must insist that all contracts, as well as arrangements for labor, services, supplies and equipment, be of reasonable value to the hospital and the public. All such contracts should be thoroughly investigated by management, subjected to possible sharing with other facilities, and exposed to competitive bidding whenever feasible.

Third-party payers must exert their influence on contractors and providers to ensure that all administered procedures are necessary and all patients are in facilities providing the level of care appropriate to the patient's condition. The assistance of PSRO's (Professional Standards Review Organizations) is often imperative.

Future Considerations

The question is: How can we achieve a better health care system at reasonable cost? In the opinion of the Hospital Commission, decisions concerning health, and especially hospital care, should be made close to home, on the state and not the federal level. While Washington State has, to some extent, retard-

ed the rate of increase of costs and charges, we, like all regions of the Nation, have to try other means to contain costs without damaging standards. National health insurance has been continually proposed as one means of cost containment. I submit that an unbridled, all-encompassing government insurance scheme is not the answer, although catastrophic insurance may well be at least part of the solution.

Another means of cost containment are the voluntary efforts now made in the health care field, which I applaud. I am disappointed, however, that the volunteers came forward only when government regulation was threatened.

Regionalization of hospitals also has been suggested. In this case diagnostic centers would be at the core with tertiary, secondary and primary hospitals referring patients according to their medical needs. Such regionalization would be organized on population need determinations made by HSAs in cooperation with state agencies and would be based on the availability of physicians and other health care personnel and on the economics of the region and its fiscal resources, including those from outside sources. This would exclude inappropriate duplications of equipment and manpower. Adversaries of this system believe this to be the end of the free-enterprise system, which in truth never existed in the health care field.

Continuity of care, whether within the hospital or without, may be another way of holding costs down for hospitals and patients. By using services based on patient needs and not, as now, on what is available, the result may be less expensive, more appropriate health care. This continuum should include nursing homes, congregate and home care, with the patient served on the necessary and appropriate level.

Periodic recertification of hospitals and other providers also may be helpful. It would close unneeded or outmoded facilities and prevent unnecessary services and incompetent

work.

Health maintenance organizations with pre-paid care, open-to-all, might well have a place in an overall system. This is different from today's HMOs, which are no better than insurance carriers, since they cannot and do not admit — except as members of a group plan — the very people who can use them most, the less economically or physically fortunate.

Capitation is another means of controlling costs and revenues, although this too may not avoid the overriding causes of health care cost inflation. There are other possibilities, and we may have to try many of them.

At the present time, sharing and merging of facilities are possibly the best ways to counteract surplus of beds, equipment, physical plants and services. But all efforts to close or redetermine uses of facilities are not going to be easy — everybody and every existing organization is protective of its own turf and jealous of the other one. Yet, we may have to force some issues, so that we can control the ever-rising costs in health and hospital care.

Certificate of Need in Wisconsin

Joseph C. Czerwinski
Wisconsin State Representative

Wisconsin's Certificate-of-Need and Hospital Specialty Decertification Law is now — in 1978 — about one-year old. The administrative rules implementing the law are newly developed or still in the process of being drafted and reviewed. Although it is too early to identify specific long-term effects of the law, there are many reasons to be optimistic about its potential as a tool for health care cost containment.

Unlike the 1122 program which preceded certificate of need (CON), the new law fills several gaps in coverage by making certain expenditures for clinics and physicians' offices subject to state review. The law's specialty decertification provision, in particular, is an innovative step that allows the state to influence existing services as well as future capital expenditures. In addition, the law also sets more stringent sanctions for failure to gain state approval for covered expenditures.

By giving health system agencies (HSAs) and the state the authority to do more than simply accept or reject submitted project proposals, Wisconsin's certificate-of-need law offers a more flexible approach to reviewing health facility expansion. HSAs and the state now have the option of approving a project in its entirety, subject to certain conditions, or approving separate parts of a project.

Another factor which contributes to the success of this effort is the fact that certificate-of-need in Wisconsin will be served by the

same administrative unit — the Division of Health — as other major health care cost control programs. These units include the Medical Education Review Committee, hospital rate review, and the Medicaid Management Information System.

I would like to briefly outline the major provisions of Wisconsin's Certificate-of-Need/Specialty Decertification Law. The law requires state approval of all major health facility construction, expansion, and purchase of expensive clinical equipment. Specifically, it covers:

- The lease, construction or purchase of a health care facility;
- A substantial change in health care services;
- A change in bed capacity;
- An expenditure of more than \$100,000 for a single item of clinical equipment, or more than \$150,000 for two or more items of related clinical equipment, if at least one of the items costs more than \$100,000; and
- Any capital expenditure not covered by the previous categories — capital expenditures are divided into two categories: health-related of more than \$100,000 and non-health-related expenditures of more than \$150,000.

The Certificate-of-Need Law covers all general and specialty hospitals, nursing homes, kidney disease treatment centers, ambulatory surgical facilities, health maintenance organizations, community-based residential facilities for more than 20 persons, and home health agencies. Beyond the certification require-

ments for these facilities, Wisconsin's law also applies — to a more limited extent — to physicians' offices and clinics. In the latter cases, approval is required only for clinical equipment expenditures in which a single piece of equipment costs \$100,000, or if two or more pieces cost a total of \$150,000 (with at least one piece of equipment costing \$100,000 or more).

In addition to the certificate-of-need requirements, the state can also decertify certain specialized services if such services are clearly and demonstrably not needed by the community being served, or if the resources of the institution are incapable of maintaining the service. The specialized services subject to the provision include the facilities, equipment and staff necessary to perform:

- Heart catheterization studies or cardiac surgery;
- Radiation therapy treatment of cancer and other diseases;
- Hemodialysis treatment of acute or chronic renal insufficiency;
- Kidney transplants;
- The intensive care and management of high-risk maternal, fetal or neonatal patients; and
- Computed tomography.

Certificate-of-Need legislation, in one form or another, has been before the Wisconsin Legislature since 1971, but passage was blocked until 1977 by the inability to arrive at a compromise which was agreeable to all concerned parties — including the Department of Health and Social Services, the hospital association, the state medical society, or myself. In 1977, faced with a federal mandate requiring certificate-of-need by 1980 or risking the loss of \$70 to \$80 million in federal funds, the divergent interest groups began to work together to pass a certificate-of-need measure.

My position was that I was not interested in a certificate-of-need proposal that did not include some type of uniform licensing provision or, at the minimum, a hospital service decertification program. I felt — and continue

to feel — that such a provision was and is as important as certificate-of-need.

Together with Sen. Paul Offner, a former member of my committee and a former employe of an areawide health planning agency, I entered into discussions with the hospital association and the state medical society. After a long negotiating process, we were able to reach a compromise that included physicians' equipment in excess of a certain dollar value, but that excluded physicians' office space and facilities. At the same time, the "uniform licensure/minimal service" concept was exchanged for the specialty decertification provision.

This coordinated effort by state government and the health care industry not only led to a quality law, but also carried over into the process for development of rules for implementation. The continued cooperation of the medical establishment with the state in implementing certificate-of-need is a positive and encouraging indication of concern for the future of medicine. The certificate-of-need rules are now in place and the specialty decertification rules are in the initial drafting stage, to be presented for public hearing shortly after the first of the year. Considering the complexity of the issues, I believe that the rulemaking process has proceeded well and with a minimum of delay. In both certificate-of-need and specialty decertification, perhaps the most important rules are those relating to the standards used to review all applications.

Specialty Service Evaluation Criteria

The Certificate-of-Need Law contains a sizable list of specific criteria for evaluating applications. Beyond these general criteria, however, the newly developed rules also contain detailed criteria for evaluating a total of eight specialized services; guidelines for several more services will be developed in the months ahead. These criteria for evaluating specialized services focus particularly on evaluation of need for the services and their relation to existing services. The rules, for example,

establish minimum utilization standards for almost all specialty services. The eight special services include acute-care services, long-term care facilities, burn centers, perinatal services, end-stage renal disease, open heart surgery, cardiac catheterization services, and computed tomography services.

The rules for specialty decertification, which are in the initial stages of development, will undoubtedly follow a pattern similar to the certificate-of-need rules with their general and specific evaluation criteria. Because the standards for decertification are not detailed in the statutes, they will need to be developed solely through the administrative rules. At least five basic criteria have been identified for further study. They include:

- Financial viability of the services: Can the specialty service be provided without overtaxing other services in the hospital?
- Utilization levels: Is the service being used sufficiently to justify its existence and to guarantee quality care?
- Resource elements: Are all necessary auxiliary services, including equipment and personnel, available?
- Appropriateness of the services: Can this service be better provided in a different setting?
- Quality of the services: Does the program use the most effective procedures currently in practice?

While all of these criteria are important, consideration of the financial viability of a service is central to the cost-containment goal. There is a strong rationale for requiring that any specialized service be able to operate on a break-even basis, rather than be a money-maker or loser. The reasoning behind this concept is that these specialized services should be operated for the benefit of a community of hospitals, rather than for just one facility. Therefore, the charges should reflect just what is needed to operate that service for all in the area who need it.

This concept is closely tied to the commitment in Wisconsin to regionalization of specialized services. While Wisconsin seeks to

maintain its many small community hospitals, we are committed to balancing their basic services with well-organized, economically viable, and readily available specialized services. It would be inappropriate for patients, who are referred for special services, to be required to pay excessive fees to support services that they were not using.

The key to determining the financial viability of a service is an accounting mechanism that allows the hospitals and state to clearly identify the revenues and expenses of a given service. Without a means of obtaining this statistical data, it is impossible to determine with any certainty the true cost factors.

Beyond the need to have adequate accounting for the purposes of decertification, these figures also will be needed following decertification action, if the hospital rate-review committee is to determine the extent of hardship resulting from the loss of service. Wisconsin's rate-review committee is responsible for approving or disapproving all hospital rate increases in accordance with established guidelines based on hospitals per patient-day costs. As a partnership of the hospital and health insurance industries and state government, the committee seeks to slow the rate of increase of hospital costs, to aid health planning by not allowing costs of unnecessary services to be used to calculate rate increases, and to create incentives for efficiency and economy within hospitals. The desirability of eventually linking the rate-review process with specialty decertification illustrates the wisdom of having these two programs administratively within the same division of the Department of Health and Social Services.

The possibility of coordinating the efforts of the Medical Education Review Committee and certificate-of-need to help hold down costs at teaching facilities is another illustration of the value of gathering all programs affecting health care cost containment under one administrative structure. The Medical Education Review Committee was set up to develop a state plan for affiliations between medical schools and hospitals. Under this plan, no

affiliation may be entered into between the medical school and a hospital without the committee's approval. If the committee has not approved the affiliation, no state funds (including Medicaid) can be used either for the program, or to reimburse the hospital or medical school for the costs of the program.

Because the costs of operating a teaching hospital are significantly higher than other hospitals, the committee has an important cost-control function. For example, it is estimated that in Wisconsin, medical centers associated with teaching facilities make up only one percent of the hospitals, but account for approximately 20 percent of the hospital costs.

For those of us who worked many years to enact this law, it is encouraging to be able to see it being implemented. The general public is just becoming conscious of the magnitude and effects of the high rate of inflation on hospital costs. I expect that we will see their awareness grow in the next few years. This public cost consciousness, coupled with the rising concern inside the hospital industry and the government, will make attainment of workable cost-containment legislation an increasingly critical issue. The degree to which that legislation succeeds in holding down health care costs will be largely dependent on the support of all segments of the community.

The British Columbia Experience

*Douglas H. Weir, Chairman
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British Columbia, Canada*

In British Columbia and all of Canada, we have a hospital and medical insurance program that is universal, comprehensive, and fully accessible. In other words, a program that is available to all residents, includes coverage for all physician services and all hospital costs (along with a few limited paramedical type services), and offers no financial or other impediment to access to the health care system.

The Hospital Insurance Program in British Columbia is premium free with operating costs met from the general tax revenue of the province as well as from federal cost sharing. A co-insurance charge of four dollars per day is paid by the patient, otherwise all services of the hospital are provided at no charge, including diagnostic services, drugs, etc.

The Medical Care Insurance Program is funded differently, through federal and provincial funding and from family premiums paid by residents individually or through employer/employee contracts. No co-insurance charge or deductible is levied against the patient who receives a physician service. The government pays 90 percent of the premium for those persons below a certain level of income (based on income tax returns) and 100 percent of the premium for persons qualifying for Social Assistance.

I also want to inject a historical note that is most important to an audience that may be

searching for parallels between the Canadian experience and what is emerging in this country. The government programs we have today were staged in two steps — first hospitals, later Medicare. Hospitals were the first to come under a national program in Canada because their financial state was the most desperate and their condition had the greatest impact on the standard of care given to patients. Not only did we have a staged introduction of our hospital and medical programs, but also a concentration on the most expensive elements of the system — namely, doctors and hospitals. Federal involvement in the cost sharing of provincial hospital insurance programs began in 1958, and Medicare became a national program in 1968. The province of British Columbia, however, has a relatively progressive record in social policies, and had its own hospital insurance and Medicare programs in place some years before there was federal involvement in administration or cost sharing.

The initial agreement with the federal government provides for roughly a 50-50 sharing of the costs by the two levels of government, federal and provincial, but the provinces were left to decide how much would be spent. Fifty-cent dollars, in the eyes of the province, were an open-ended arrangement. The provinces therefore tended to spend freely in a field that, during the 1960's and early 1970's, was politically popular. Three or four years ago, the temper of the times began to shift and we had to seriously consider cost containment, possibly even cost reduction, strategies.

We are obviously experiencing most of the same pressures on our health dollars that you are: an increased number of aging population, the fight against diseases that are becoming more sophisticated, and the response by medical science with more and more expensive technology. With the major gains in lengthening average life expectancy already behind us, we are experiencing ever-diminishing health returns from increasingly large sums invested in care delivery.

It is difficult to compare cost containment performances in the United States and Canada because of the basic differences in our health systems. One measure of comparison that is often used, however, is to express health expenditures as a percentage of the Gross National Product. Studies have shown that in 1960 health expenditures in the United States were 5.3 percent of the GNP, whereas in Canada they were slightly higher at 5.5 percent. In 1976 this position had changed considerably with the United States' percentage standing at 8.3 percent of the GNP, and Canada's at 7.2 percent. What is significant, perhaps, is that in the five-year period from 1971 to 1976, a period of full government coverage of hospital and physician costs, the percentage in Canada moved only from 7.1 percent to 7.2 percent of the GNP, whereas in that same period, the United States' percentage went from 7.5 percent to 8.3 percent of the GNP.

New Program Initiatives

Two years ago, the federal government presented the provinces with proposals for a completely new system of financing health care. This is now in effect and ties increases in the federal portion of shared-cost health programs to increases in the GNP. This is having the effect of closing off previous open-ended agreements and is causing the provinces to strengthen their control of the health system, so that costs will not become exorbitant.

One of the advantages to the provinces of the new cost-sharing arrangements is the

greatly increased flexibility which it allows. The previous funding was tied to, and could only be used for, costs of acute-care hospitals and physician services and — fifty-cent dollars being available for these items only — tended to channel all resources into these two areas. Under the new arrangement, no strings are attached to the federal funds. Therefore, because of the "closed-end" nature of the funds, there is an incentive for the provinces to opt for less costly alternatives in delivery of health care.

The result, starting last January 1, 1977, was introduction of our long-term care program which, at this moment, has about 15,000 beneficiaries and is still in the developmental stage. Under this program, extended and long-term care is provided at a cost of \$6.50 per day; persons unable to pay this portion of the cost can apply for assistance through the government Social Assistance Program. This program has already taken some of the load off acute-care hospitals. We are also pursuing a strong bed-reduction policy and intend by 1986 to reduce the number of our acute-care beds from the present 5.2 beds to 4.25 beds per 1,000 (including psychiatric and rehabilitation beds).

This does not mean that we are decelerating hospital construction. Since our hospitals are in the public sphere, their capital costs, which are shared 60/40 between the provincial government and regional district taxpayers, are raised through tax dollars that are increasingly under pressure. Nevertheless, it is necessary to continue to replace outdated and antiquated facilities. During the next seven years, the British Columbia Health Ministry has allocated \$700 million to such capital projects.

In terms of hospital activities, we also are striving for cost containment by promoting ambulatory care programs which include such arrangements as day-care surgery and outpatient clinics. Our day-care surgery program has had excellent results in some areas, where as much as 30 percent of the surgical workload is now being done on a day-care basis.

On a broad policy level, since 1975 we in Canada have had ceilings imposed on wages and salaries by a federal agency called the Anti-Inflation Board. Since 80 percent of the costs of our hospitals are wages and salaries, undoubtedly Anti-Inflation Board guidelines have had a positive effect in terms of immediate cost containment.

The Anti-Inflation Board maximum salary guideline — applied to salaries of hospital workers — was eight percent in 1976, six percent in 1977, and four percent this year (1978). During those same three years, we could only negotiate with our doctors an increase to cover proven costs of their increased overhead plus a maximum of \$2,400 per annum to average pass-through income before taxes for each physician. Only after controls are lifted next year, 1979, will we be able to see whether there has been a long-term effect. Some observers predict that we will rebound into a period of "catch-ups."

The activities of our public health nursing workforce also have been widened to encompass an early-discharge, home-care program. The program provides home visits by nurses, physiotherapists, and other health professionals to persons who have been discharged from the hospital earlier than would normally be the case. We are experiencing many reductions in length-of-stays for surgical and medical patients because physicians are now assured that their patients can obtain adequate and appropriate home care.

The province of British Columbia is also implementing cost containment strategies through its Medical Care Insurance Program under my administration. Our physicians bill the medical plan on a fee-for-service basis. The value of individual fee-items is determined through annual negotiations with the British Columbia Medical Association, which represents our doctors' economic interests. For several years, the fee-for-service system was far too open-ended for the comfort of anyone in public office. I think we have gone some distance in negotiating a measure of control. Please note I use the word "negotiating,"

meaning that the state of equilibrium we now have with our physicians is the product of a bipartisan process.

Costs for diagnostic tests have tended to increase at a faster rate than other medical costs. One of the problems is that the fee schedule has not kept pace with the advances in technology. More and more automated procedures come into use, yet we continue to pay at manual-procedure fees, losing the economies of large-scale batching. We find that we are paying the inefficient laboratory to continue to operate, while providing the large efficient laboratory an excessive profit. This problem is now being addressed by extensive costing studies.

We have managed to rationalize the growth of private laboratories by establishing strict accreditation criteria and requiring commission approval before a facility may bill the medical plan for its services. We will not pay a medical laboratory for certain tests if it obviously does not have the necessary professional or technical skills. Nor will we allow establishment of a new lab or expansion of an existing lab if other, already approved laboratories in the geographic area have unused capability. We are also gradually eliminating by attrition those labs in which the referring clinical physician has a financial interest and therefore an incentive to increase the volume of diagnostic tests.

The same limitations apply to radiological procedures. Approval and accreditation criteria in both cases are established by committees representing both the medical profession and the government.

We also have restricted ultrasound equipment to hospitals; ultrasound is simply not used in physicians' private offices in British Columbia. For example, we are not permitting an uncontrolled proliferation of costly CAT scanners. To date, we have approved only three whole-body and two head CAT scanners for all the hospitals in the entire province. Unlike the United States, we have no intention of permitting this type of equipment to be set up in the private offices of radiologists and

neurologists. Also, we are not allowing this type of service to be paid on a fee-for-service basis: such services are provided on a sessional basis. The unnecessary duplication of such facilities and their consequent underutilization can have only one effect — overpricing to compensate for uneconomical functioning if the facilities are to pay for themselves.

In addition to such direct and obvious controls, we carry out reviews of patterns of practice that can isolate individual physicians whose Medicare billings deviate widely from certain pre-established norms or averages for specialty or location. This has not been as effective as we would have liked, so we are stepping up this peer review activity. Government involvement will be greatly increased in what was previously a field of responsibility entirely given over to the medical association.

We have found a direct relationship between physician supply and Medicare costs. British Columbia has an oversupply of physicians, with a considerable oversupply in the two large urban centers of Vancouver and Victoria. Oversupply generates over-servicing, and we are presently tackling this oversupply and maldistribution problem by a task force committee. In addition, we are implementing on October 1, 1978, a "northern and isolated" allowance in the form of a graduated percentage bonus applied to the entire fee schedule for areas that are isolated or underserved.

Our administrative costs may be of interest as a comparison to some of your own plans such as Medicaid or Blue Cross. The medical plan of British Columbia is highly computerized and our administrative costs last year were just under four percent of total expenditure.

The physicians of British Columbia, under our legislation, may freely "opt out" and practice outside the plan, collecting directly from the patient and leaving the patient to collect all or part of the payment from the plan. I think it is significant that not one physician in British Columbia has chosen to opt out of the plan. As long as the physician chooses to operate within the plan, he may not

charge the patient extra, but must accept our payment as payment in full. I would be less than truthful if I said that all was sweetness and light between government and the profession. Items of confrontation constantly surface and we have to find a way through mutual discussion to overcome these problems.

The greatest difference between the health systems of the United States and British Columbia is that ours is almost entirely in the public sphere. It is within a political economy, not a market economy. This means that any large-scale cost containment measures will have to be abridgments to a social contract. Such modifications have to be made in the political context.



III. HEALTH MANPOWER IN TRANSITION



Manpower

Many of the controversies implicit in the recurrent national health insurance debates concern accessibility to the health care delivery system which, in turn, reflect allegations about scarce and maldistributed health manpower. With the problems caused by technological innovation, new delivery mechanisms, and increased emphasis on equitable access, more policymakers are becoming alert to the possibilities available through manpower planning.

Such planning not only encompasses supply and distribution of traditional allied health professionals, but also anticipates the demand for new training and specialties necessary to implement emerging health care technologies and delivery mechanisms.

The goal of federal national planning efforts may directly confront local planning attempts to ameliorate selective manpower shortages in certain areas. Gloria Ruby, from the Institute of Medicine, points out that the United States is expected to have an oversupply of physicians in the near future; yet this increased aggregate number will not necessarily increase the number of physicians in primary care, and it may not improve access to care for underserved areas. Excerpting from an Institute of Medicine study which she co-authored, "A Manpower Policy for Primary Health Care," Ruby comments that the study's recommendation to curtail any further increase in the aggregate supply of physicians is based on the contention that more physicians will add considerably to health care expenditures.

Ruby discusses a few of the study's recommendations to forestall an increase in the aggregate number of physicians, while also alleviating the physician shortage in some areas. One suggestion called for eliminating the existing inequities in third-party reimbursement levels for primary care services. Another proposal was removal of reimbursement level differences for primary care services rendered in various locations within a state — a change also endorsed by HEW's Health Care Financing Administration. Ruby believes that both of these strategies would relieve the current maldistribution of physicians.

In the state arena, North Carolina's comprehensive rural health planning program illustrates how a program's centralized organization can enhance its effectiveness. The North Carolina Office of Rural Health Services (ORHS) planning program, emphasizing primary health care services, coordinates both manpower and facility development.

Nan Rideout, ORHS Health Center Development Specialist, describes how that program is targeted for underserved rural areas. It assists localities in establishing and maintaining primary health care facilities and the necessary professional staff. Much of the program's success, she believes, is due to the fact that the state invests *one* agency with the requisite funding capability and program flexibility to attain its objectives.

In developing community-sponsored health care systems, the ORHS retains flexibility when responding to community needs. This position, Rideout explains, results in commu-

nity health care facilities that vary considerably in sponsorship, size, and organization. Before funding a project, ORHS carefully reviews each community proposal, conducting an economic feasibility study of the proposed facility's potential for self-sufficiency by its fifth year. Moreover, Rideout adds, the state agency adheres to strict criteria requiring financial support from the community in return for state assistance.

In addition to problems of selective shortages and maldistribution of health care professionals, the increased number of new specialty groups among the allied health professionals has created new problems for policymakers. Many of these new groups have been seeking legitimacy and protection of occupational "turf" through statutory delineation of each separate and distinct professional practice area. The result has been a proliferation of new legislation relating to licensure of new groups.

Reacting to this cumbersome method of regulating health occupations, Minnesota embarked on a bold new program to rationalize its system of professional licensure. Corrine Larson, Director of the Division of Manpower, Minnesota State Department of Health, details that state's 1973 Allied Health Credentialing Act, which created a mechanism to replace excessive fragmentation with "families" of interrelated occupations.

To begin implementing the law, the state health department commenced an exhaustive examination of a broad range of occupational families. Larson explains that the objective of this study was to determine which unregulated subgroups might be regulated in the future, by whom, and by what standards.

"I stress the pioneer nature of the study process," Larson says, "because for the first time in Minnesota, and probably for the first time in the country, a process was developed that did not make a decision regarding the need for recognition of one occupation in isolation, but in relation to all other occupational groups in the entire family." Although this process was applied only to occupational

groups that were not yet regulated, Larson points out that it is having a favorable impact on current practices of existent licensure boards.

Another aspect of Minnesota's Allied Health Credentialing Act is the Human Services Occupations Advisory Council. The Council is charged with promoting cooperation among the various licensure boards and developing guidelines to review rules implemented by the existing health-related licensure boards. As part of fulfilling this mandate, the Council has released generic policies and guidelines for professional advertising, licensing board composition, continuing education, inactive status, reciprocity and credential endorsement. Larson notes that several of the boards recently sought modification of their rules in order to comply with these newly developed guidelines.

The Council also directed its attention to standards of performance for these occupational groups. Competency-based standards were formulated to replace the traditional academic credentials as eligibility criteria for entrance into a profession. Quality of practice was the primary determinant in compiling new standards, Larson explains. "We think that traditional academic credentials are not necessarily sound indicators of accomplishments or performance."

Larson also details extensive Council efforts to solicit and encourage public and professional input during the lengthy process of profession review. Whenever possible, she notes, the Council endeavors to promote greater coordination of requisite professional credentials among the State Health Department, state planning agencies, the Board of Education, as well as other involved agencies and organizations. As an adjunct to the Council's information collection and review processes, the state initiated a comprehensive Health Manpower Information System Data Base. Such data assist local planning and identify manpower training needs for the state education department.

"The process we have established," Larson

says, "emphasizes systematic study, community input, coordination among agencies and development of competency-based standards — all of this before any recommendations for regulation are made." Fully cognizant of the turmoil such an undertaking may create, Larson advises states considering similar action to have their legislature define which groups are to be encompassed by the review process.

Similar cooperative efforts toward manpower planning are also underway in the Canadian Province of Saskatchewan. Cooperative planning activities there enlist the involvement of other provinces to address the problems of local health manpower supply and distribution, according to Donald Philippon, Senior Research Officer, Health and Social Services Programs, Saskatchewan Department of Continuing Education. He describes this province's successful manpower planning program, one that starts at the level of initial professional education. Like all successful health planning, Philippon states, the program focuses on methods by which planning can initiate change in the health care delivery system.

Philippon particularly extols coordination of decision making between the highest levels of the provincial departments of health and education. "The key element in the Saskatchewan approach," he stresses, "is the close coordination between the health and education sectors." All too often, he adds, planners forget that meaningful health manpower planning "can only take place after the nature of the desired changes in health services and the nature of the desired effects on the health status of a population are known."

Canadian provinces participate in national and regional committees — e.g., the Federal-Provincial Health Manpower Committee and the Western Canada Health Manpower Committee — that orchestrate future availability of the various health manpower specialties. Listing the planning methods undertaken at the educational level, Philippon mentions, as helpful tools, utilization of enrollment quotas,

financial aid stipulations, and grants to encourage professionals to practice in underserved areas.

As an example of an innovative program resulting from these described planning activities, the Canadian official details the development of the Saskatchewan Dental Plan, started in 1972 to provide restorative and preventive dental services to children between the ages of 3 and 12. Designed to alleviate the shortage and maldistribution of dentists, the program utilizes dental nurses and dental assistants under a dentist's supervision.

After need was determined, the planners found that there was a shortage of the necessary professionals, a shortage that even immigration of these allied health groups could not remedy. To rectify this limitation, an extensive training program was devised to provide the needed professional groups in sufficient numbers. The training program was implemented through a local school and dental care was provided through 263 school-based clinics. In Philippon's opinion, "Close cooperation between the health and education authorities must certainly be singled out as a prime factor in the swift implementation of the Dental Plan."

Apparently, this program has provided a good test of the province's manpower planning capabilities, as well as its ability to coordinate the health and education sectors. As evidence of the program's success to date, Philippon points to a recent study showing not only that the quality of the work of dental nurses was equal to or better than dentists, but also that the program greatly increased children's access to dental care at a cost less than in the private sector.

Moreover, Philippon notes some encouraging signs regarding the program's ability to provide preventive dental care, indicating success in changing attitudes toward dental care. The frequency of recalls for further dental work, he says, has been lower than what was originally expected, although he cautions that it is still too early to evaluate the program's effectiveness in preventive dental

care. As an illustration of the Saskatchewan manpower planning method, however, the Dental Plan has — even at this early stage — registered an impressive log of accomplishments in improving accessibility to services through innovative utilization of health professionals.

Selected Issues in Health Manpower

Gloria Ruby, M.A.

I have been asked to discuss the key manpower issues related to the appropriate delivery of health care, the generic issues of the supply, and the specialty and spatial distribution of health manpower. I shall focus my remarks on the recent report, "A Manpower Policy for Primary Health Care," prepared at the Institute of Medicine (IOM). In attempting to formulate a cohesive policy for increasing the accessibility and appropriateness of primary care delivery, the report addresses these issues in considerable depth.

The study emerged from the IOM's concern that health manpower policies meet primary care needs. The importance of an adequate supply of primary care manpower had been emphasized in many reports during the 1960's. By 1976, the Congress declared, in the 1976 Health Professions Educational Assistance Act, that the general availability of health care depends to a large extent on the availability of primary care practitioners.

The IOM committee appointed to study the problem consisted of 14 members and represented a balance of disciplines as well as viewpoints. The study did not develop original data, as have some other Institute activities, but based its recommendations on the analysis of available empirical data and the professional judgement of the committee members.

The study's goal was to produce a set of recommendations for assuring an appropriate supply of trained primary care practitioners providing primary care to all populations in the United States. In order to refine this goal, the committee initially developed a definition of primary care. This definition, which is based on the scope, character and integration of services provided, defines primary health care as accessible, comprehensive, coordinated, continual care delivered by accountable providers of personal health care. Primary health care is thus distinguished by the nature of the services provided and not the particular training of the provider. Although a wide variety of health professions are engaged in primary care, the report emphasizes the activities of physicians, nurse practitioners and physician assistants.

Most of the 20 recommendations developed by the committee relate to the supply and distribution of primary care practitioners and, although conceived as a national document, the role of the states is not overlooked. Indeed, Chapter 6 of the report lists state legislatures and state agencies, along with federal and private bodies, as two of the groups responsible for implementation of 15 of the 20 recommendations and for providing guidance or pressure for their implementation.

I shall comment on a few of these recommendations of special interest to you in state

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government. First, I would like to address the issue of adequacy of physician supply. The overall supply of physicians in the United States increased 30 percent from 1968 to 1975. With the continuation of current enrollment trends, the Bureau of Health Manpower (BHM) of the Health Resources Administration estimates a continued dramatic increase. In 1990, the United States is expected to have about 594,000 physicians. It is generally agreed this large increase in the total number of physicians will produce an overall supply of more than 200 physicians per 100,000 population, compared to 157 physicians per 100,000 population in 1975.

To forestall an even further increase in the aggregate supply of physicians, the committee recommends that the number of entrants to medical school be maintained at the current annual level. The recommendation is based on the consideration that the overall supply of physicians is, or soon will be adequate, that increasing the aggregate supply of physicians will not necessarily increase the supply of physicians in the commonly accepted primary care disciplines, and that the increasing overall supply of physicians will add significantly to health expenditures. The market power of physicians as independent professionals allows them to influence the demand for their services as well as the demand for hospital care, drugs, laboratory services and other ancillaries. Some health economists, for example, Uwe E. Reinhardt and Eli Ginzberg, contend that each additional physician increases health expenditures by \$250,000 per year.

The argument of free market economists that an oversupply of physicians will force physicians to enter those disciplines where there are now shortages, or to practice in underserved areas, has yet to be demonstrated, and is contradicted by the current large physician/population ratios in the northeast. Thus, an adequate supply of physicians guarantees neither adequate services for all geographic areas, nor adequate numbers in all specialties.

Nonetheless, the question of physician supply is as much a question of perception as

a question of numbers. If people do not have access to a physician, a physician shortage exists for them, making it difficult for some state legislatures to accept a policy of not increasing the number of entrants to medical schools when selective shortages are still part of the experience of some of their constituents. It is therefore essential that the public and their representatives be informed of the relationship of overall supply to distribution, as well as the relationship of overall supply to health care costs.

The next issue the IOM committee addressed, and that I wish to comment on, is specialty distribution. There was general agreement among committee members (and most other policymakers) that more physicians should be trained to deliver primary care and more physicians should be encouraged to enter and remain in primary care practice. Despite the expected increase in the aggregate supply of physicians, the committee foresees a continued shortage in those disciplines commonly accepted as primary care specialties. The primary care specialties recognized in the Health Professions Education Assistance Act (HPEA) are family and general practice, internal medicine and pediatrics, while the American Medical Association also includes obstetrics and gynecology.

According to the AMA definition, primary care physicians represented 44.8 percent of the total supply in 1975. Given current trends and policies, the percentage of physicians in primary care specialties is projected to increase to only half the total supply of physicians in 1990. Calculations of the BHM, prepared after the publication of the IOM report and using the HPEA definition, place the percentage of physicians trained to deliver primary care at 38.4 percent in 1975 and 44.5 percent in 1990. This last number may be overestimated. It does not account for the fact that 60 percent of residents in internal medicine and the 20 percent of residents in pediatrics enter subspecialty training programs after their third year of residency training. Nor does it account for the fact that 15 percent of pri-

mary care physicians leave practice to obtain retraining in another specialty.

Many strategies to shift the specialty distribution of physicians concentrate either on the period of medical education or on third-party payments to physicians. The IOM report recommends using both approaches.

The report recommends using judicious change in the structure of third-party payments to physicians to make primary care more financially attractive to the physician. There are recognized limitations to the effectiveness of financial incentives and an incomplete understanding of their influence on the delivery of health services. Nevertheless, reforms are needed because current payment practices place no premium upon the delivery of primary care services and, in some instances, discriminate against such services. Three of the report's recommendations attempt to redress this inequity. They are: eliminating differences in payment for primary care services across specialties; reducing the differentials in payment levels between primary care procedures and nonprimary care procedures; and instituting payments for preventive and health education services considered essential to good primary care practice but not currently reimbursed. These recommendations are addressed to all third-party payors—private, federal and state.

The public role, particularly that of the federal government, in effecting specialty distribution in the education arena has been aimed at regulating the distribution of residency slots by requiring that 50 percent of medical school-affiliated residencies be in primary care specialties. The report recommends a substantial increase in the percent of first-year residents in primary care.

The report recommends, as well, that federal and state governments continue their support of primary care by the continued use of financial incentives to create primary care residency programs. The states to date have been supportive in funding and establishing family practice departments, especially in state universities. The support of family training programs is not only a desirable way to rein-

force primary care in medical education, but also is useful in alleviating the geographic maldistribution of physicians.

Spatial maldistribution is the last issue I shall discuss. Unlike physicians in general, family physicians are concentrated in rural areas. In 1976, 54.9 percent of all family physicians were located in cities with populations of 30,000 or under, including 11 percent who practiced in cities between 2,000-5,000.

Geographic maldistribution of physicians exists among states, between metropolitan and nonmetropolitan areas, and within urban areas. About 40 to 50 million people in rural and low-income areas are estimated to lack access to physician services. In order to eliminate financial disincentives for primary care physicians to practice in underserved areas, the committee recommends that all third-party payors—federal, state, and private—should discontinue all differentials in payment levels for primary care services within a state. This recommendation is similar to a proposal by HEW's Health Care Financing Administration (HCFA) to institute statewide fee schedules with uniform procedure codes for all specialties.

In sum, IOM's recommendations suggest specific strategies to follow regarding an adequate supply of physicians and appropriate specialty and geographic distribution of physicians. They are not the only avenues that can be used. The issues are complex and of long standing, and require many approaches and the involvement of parties on all levels of government, as well as health professional and public bodies. But before changes can be made, it is necessary that the public and their representatives understand the complexity and interrelationships of health manpower issues.

There is a growing awareness among those interested in providing equitable access to health care that the federal government may not be the sole or proper agent to deal with all distribution issues. States, local governments, Health Systems Agencies and medical schools may be more knowledgeable and thus better equipped to identify shortage areas.

North Carolina Experience: A State-Level Initiative in Improving Primary Health Care Access

*Nan Rideout, Health Center Development
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Rural Health Services*

The North Carolina Office of Rural Health Services is a unique example of a state's commitment to a comprehensive role in improving access to primary health care in rural areas. The emergence of this effort grew from the reality that North Carolina is a predominantly rural state with a high proportion of its rural counties lacking adequate access to sources of primary medical care. In 1972, 60 of its 100 counties had a population-to-physician ratio of over 4,000:1.* Acting in response to this need, the state legislature took an initiative in 1973 which was unprecedented among state governments, establishing the North Carolina Office of Rural Health Services (ORHS), with a broad mandate to impact primary health care access using state funds.

The initial approach of the ORHS was the development of community sponsored rural health centers staffed by family nurse practitioners or physician assistants. By 1974, this approach had broadened to include a specific program of physician recruitment as well. Thus, the ORHS program emphasizes the development of health care systems with strong community bases utilizing physician extenders as well as physicians.

Field representatives from the office provide regional coverage of the state, responding to

community requests and assisting community groups that are considering primary health care alternatives. The major objective of this effort is the establishment of permanent sources of primary health care through community organization, funding assistance, and program and management education. A goal of the office is to develop community based groups capable of procuring primary health care for their constituencies in the future, without dependence on long-range state or federal assistance.

Community Based Health Centers

The North Carolina ORHS initiated its program to alleviate the need for primary medical care in rural areas by utilizing community grants and comprehensive technical assistance to establish rural health centers staffed by physician extenders. Such centers offer a broad range of primary health care under the standing orders of a backup physician who is usually located in a nearby town. Complicated problems and procedures are referred to this backup physician.

Ownership and management of the local health center is vested in a non-profit tax-exempt community corporation. Centers are located throughout the state in areas with an obvious lack of accessibility to primary health care.

Each local health center setting differs in sponsorship, size, and organization. The office is able to be extremely flexible in meeting the

*These ratios are for physicians under 60 years of age. By 1974, the number of counties with such a critical physician shortage had grown to 67.

needs of the individual communities, but only communities that initiate contact with the office and show strong evidence of need, demand, and financial feasibility are considered. Local boards of directors usually have broad geographic and ethnic representation from the service area.

Commitment to a community selected for the program is for several years. The first year is completely developmental, involving program development, community management training, facility development, and staff recruitment and training.

The backbone of the ORHS operation is the field staff which coordinates the above resources to provide flexible and realistic plans tailored to specific community situations. A major contribution that the office makes is in the area of technical assistance to community groups. Field representatives are skilled in providing community organization assistance, management training, facility design, implementation of business systems, and general problem solving for each community project. Technical assistance for facility design includes architectural programming, with an emphasis on the health program being developed and the development of a basic schematic layout, if appropriate.

The office has funds to assist communities designated to develop health care centers under the program. These funds include capital financing and financing of operational deficits for three or four years. Capital financing is provided to match community funds on a five to one basis. These local contributions must be raised from a minimum of 500 households. State funds for facility development include monies for equipment and furnishings.

State funds for operation of these centers are reduced over a four-year period with the center planning to be self-sufficient by the fifth year. Because of this constraint, an economic feasibility study is done of the potential service population before commitment of state funds to such projects. Though no one is refused service because of inability to pay, centers do operate with a fee schedule similar

to those of nearby physicians and seek to establish an image as a provider of services for all persons in the communities where they are located.

In summary, the Office of Rural Health Services works with the goal of developing effective and informed community groups. It believes that only by building strong community bases which are equipped with the necessary management tools and health care perspective can communities maintain accessibility to primary health care in the future.

Physician Placement

The recruitment of physicians through a comprehensive nationwide effort evolved as the health center program grew. This effort has been based on a program philosophy which emphasizes full assistance to both physician candidates and needy communities in an effective matching process. Thus, ORHS physician recruitment goes beyond the brokerage function to work toward establishment of physician practices which will have stability over time. Physician placement includes emphasis on assistance to primary care residents as well as general national advertisements aimed at relocating physicians. The former effort includes close coordination with the faculties at North Carolina's four medical schools and the assignment of individual ORHS field staff to each residency program.

Kinds of placement assistance to residency programs include technical assistance in evaluating and establishing practices (market analysis, management training, business systems), facility design, careful determination of the location goals of residents and spouses, and the provision of current information on practice sites available.

Although it is anticipated that most of North Carolina's physician needs will be met by in-state residents within the next five years, ORHS also is currently involved in a nationwide effort. A mass mailing, totalling over 20,000 pieces last year, is sent yearly to first, second, and third-year residents. Advertising

in major medical journals is also a key element. Centralizing this advertising effort for the state permits the development of a yearly plan which allows the placement of ads at crucial points throughout the year. Most small communities would find such cost of running an advertising program prohibitive.

In addition, ORHS has assumed responsibility for improving rural health care delivery by acting as a liaison for National Health Service Corps projects in the state. This has expanded options available to the community and also insures the program's ability to provide comprehensive assistance to the physician.

The office is also involved in a new project sponsored by three local foundations to interest more minority physicians in practicing in underserved communities in North Carolina. This effort involves expansion of the number of practice opportunities in the state for minorities and the development of outreach programs in key residency centers throughout the nation.

A valued complement to the ORHS recruitment effort is the North Carolina Area Health Education Centers Program (AHEC), also funded by the state legislature in 1973 to decentralize medical education and improve the distribution of health manpower in the state. The ORHS physician recruitment effort is reinforced by the AHEC residency training programs located throughout North Carolina, which expose residents to the nature of rural practice. The Continuing Education Outreach programs of AHEC also provide a valuable support function for rural physicians and serve as a force for retention of physicians placed through ORHS efforts.

The North Carolina experience in granting one office (ORHS) the funding capability and program flexibility to provide comprehensive assistance to rural areas lacking adequate access to primary health care has been rewarding. To date the office has designated 21 such rural health centers and additional communities are in the development process. In the three years the physician recruitment effort

has been underway, more than 100 physicians have been placed. The total impact of ORHS efforts has resulted in improved primary care access to more than 250,000 rural North Carolinians.

Report from the Manpower Division, Minnesota Department of Health

Corrine W. Larson, Director, Division of Manpower

For the last eight years policymakers in both governmental and nongovernmental circles have been concerned that the ways we traditionally credentialed and regulated health and human service manpower caused barriers to their most efficient utilization — that our continued practice of licensing new occupations as they emerge increases fragmentation in the provision of services to our clients and patients.

Two movements now occurring in this country together make possible a system of health personnel regulation which helps ensure the development of more effective and better coordinated health care services. One is the reform of occupational licensing practices which has begun in state legislatures around the country. The other major movement is the formation of the Commission for Health Certifying Agencies, designed to improve the processes for certification of personnel in the nongovernmental sector.

The Minnesota Division of Manpower, under my direction, is one example of the reform of occupational licensing practices undertaken by state legislatures. As Director, some of my legislatively mandated responsibilities include:

1. Recommending to the Commission of Health and the legislature which of these unregulated health and human service occupations should be regulated and how;

2. Carrying out the registration or licensure of groups when the authority for such regulation is with the Commissioner of Health;
3. Serving as the Minnesota Department of Health liaison to the traditional health-related licensing boards; and
4. Developing a common credentials policy and reviewing and commenting on the rules and policies of the traditional health-related boards.

It was almost seven years ago that the Minnesota Planning Agency and legislative leaders began to study the labor-intensive health care industry and the traditional regulation model of licensure for health personnel. At that time, ten autonomous health-related licensing boards regulated 16 categories of health manpower. Further, an increasing number of new groups were approaching the legislature each session with licensure requests. A mechanism needed to be developed that would assure an orderly process of identification of occupations that needed to be regulated for the protection of the public and, at the same time, avoid unnecessary proliferation of regulated professionals and exclusive occupational turfs. Critics noted that the traditional model of licensure resulted in fragmentation of regulatory efforts among separate autonomous licensure boards and an inflexibility which prevented utilization of new techniques or innovative uses of new or existing personnel. Since each licensure law, by definition, ensures an exclusive area of practice for the licensed group, a licensed occupational

group could neither readily alter its scope of practice, nor admit other practitioners into its exclusive practice area. This latter point became particularly important as professional groups emerged to accommodate new technologies, new delivery structures, and new practice demands in the health care system.

Starting in 1969, the Minnesota Comprehensive Health Planning Program carried out studies, convened task forces, and debated suggestions in its advisory council. Finally, in 1971, legislation to change the traditional licensing scheme was recommended. The need for regulatory reform was evident and the legislature met the challenge by passing enabling legislation in 1973 as the Allied Health Credentialing Act. The major responsibilities contained within this legislation include:

- Recognition of human services occupations useful in the effective delivery of human services;
- Coordination of the development of credentials policy among the health-related boards; and
- Establishment of an advisory group, the Human Services Occupations Advisory Council, to make recommendations to the Commissioner about the need for and the form of regulation of additional occupational groups.

The initial work necessary to carry out this legislation was a pioneer effort of detailed studies of various occupational families. By families I mean, as an example, the 13 occupations that relate to vision care: Ophthalmologist, Ophthalmic Medical Technician, Ophthalmic Medical Technologist, Ophthalmic Medical Assistant A, Ophthalmic Medical Assistant B, Orthoptist, Contact Lens Technician, Optician, Ocularist, Optometrist, Optometric Technician, Optometric C.L.T., and Optometric Assistant. Continuing with this same example (although it applies to other occupational families as well), the study required that for the first time each type of vision care specialist sit down around a table to discuss in detail their individual functions, usual work setting, tasks performed, pre-

service educational preparation, and a host of other considerations. Other occupational families applied the same procedure.

It was and is a difficult process, and enormously time consuming, but it was an absolutely essential step preliminary to any decision regarding which occupational group in a particular family needs to be regulated, by whom, and by what standards. I stress the pioneer nature of the study process because for the first time in Minnesota, and probably for the first time in the country, a process was developed that did not make a decision regarding the need for recognition of one occupation in isolation, but in relation to all other occupational groups in the entire family.

As of today, several occupational families have been studied and 14 credentialing decisions have been made. Eight decisions for registration were for: Emergency Medical Technicians, Sanitarians, Speech Pathologists, Audiologists, Chemical Dependency Professionals, Contact Lens Technicians, Emergency Paramedics, and Physician Assistants. Four no-credential decisions were for Ophthalmic Medical Assistants, Medical Laboratory Personnel, Behavior Analysts, and Hearing Aid Specialists. Also, one preliminary licensure recommendation for X-ray Machine Operators is being refined to determine and define appropriate competency and training levels. This recommendation will be brought to the legislature with all the background work completed and adequate data to support the recommendation. During this year we anticipate making one more credentialing decision and studying eight more applications: Nurse Midwives, Marriage and Family Counselors, Personnel and Guidance Counselors, Acupuncturists, Athletic Trainers, Occupational Therapists, Naturopaths, and Veterinary Technicians. Rules for the eight to-be-registered groups are being written, with five very near completion. In addition, studies are underway concerning the Health Administration occupational family and Nursing Assistants. As you can see, we deal with very diverse groups and some complicated issues.

To ensure community and public input, we keep several current mailing lists, include meeting announcements in a monthly department newsletter, and retain current files of official credentialing records in several locations throughout the state. Each credentialing recommendation is supported by a comprehensive file of documents, data, details of every procedural step, and all other materials submitted during the process. These files are available to the regional Health Systems Agencies and Health Department Offices. We also have an extensive mailing list which includes state licensing boards, professional associations, consumer groups, applicant group representatives, and other interested individuals. Additionally, public forums are held in one or more locations in the state during each application deliberation. In our information dissemination efforts, as well as in our credentialing process, we have gone beyond what is required by law in order to secure broad input.

In order to ensure a positive impact on the delivery system, the scopes of practice in the rules for specific groups are written to dovetail with the responsibilities of other public agencies involved in the regulation either of the group or of the employing agency. For example, we are working with the Board of Teaching to ensure coordinated standards for human-service workers employed in the schools.

We also are attempting to develop competency standards as an outcome of the credentialing process so that quality of practice is the key criterion. This is a change from the tradition of virtually requiring graduation from accredited training or other educational programs and/or testing graduates on what they learned in these programs. We think that traditional academic credentials are not necessarily sound indicators of accomplishments or performance.

The Division of Manpower is working to eliminate grandfathering; to develop, where possible, more than one entry route; to design renewal requirements, where possible, based

upon job performance; and to define incompetence for disciplinary purposes. The process we have established emphasizes systematic study, community input, coordination among agencies, and development of competency-based standards — all of this before any recommendations for regulation are made.

Related Activities

In addition to the credentialing decision making and regulatory activities, we perform three other major functions to fulfill our health and human service manpower development responsibilities. These are:

- Health Manpower Information,
- Licensing Board Coordination, and
- Human Service Manpower Policy Coordination.

To aid the state in planning for health manpower needs, we have established the Health Manpower Information System through legislation enabling collection of detailed health manpower information. This was important because more complete information than could be gathered on a voluntary basis was necessary for policymakers. The system is an ongoing data collection and analysis activity intended to provide statistical and descriptive data for health planning purposes at the local, state and federal levels.

The data collected by the system consists of demographic and professional characteristics of persons regulated by the State of Minnesota in the health-related professions. Surveys are sent to individuals on an annual basis, coinciding with license or registration renewals. Descriptive summaries based on aggregate data at the county and HSA levels, and the aggregate data without individual identifiers, is provided on an *ad hoc* basis in response to requests from state agencies, HSAs, researchers and educators.

The system I have described, deciding who should be regulated and how, is applicable to the “not-now-regulated” groups. Thus far, no one has suggested that the same criteria be

applied to already regulated groups. However, as part of our overall responsibility to establish credentialing policy, we are attempting to promote board coordination and cooperation through development of guidelines to review the roles of existing health-related licensing boards. A task force of the Human Services Occupations Advisory Council has implemented a process that includes numerous open meetings and public forums to establish these guidelines. The Advisory Council has approved policies and guidelines for advertising, licensing board composition, continuing education, inactive status, reciprocity and credential endorsement. Notably, several of the boards already have sought statutory changes in keeping with these guidelines.

Since health and human services manpower planning, production, and implementation responsibilities are located in several different state agencies, coordination of manpower policies and resources is necessary if the state is to have an effective and efficient manpower delivery team. The State Health Department, the State Planning Agency, and the Higher Education Coordination Board have developed interagency agreements that speak to procedures for identifying priority issues, sharing information, developing joint studies, and sharing agency resources to accomplish this goal. We are currently in negotiation with the Department of Welfare for the same purpose relating to mental health personnel.

Legislative Issues

With our existing statutory authority, we have successfully laid the foundation for an administrative system of regulatory reform. An effective process is now operative, although certain issues will need to be addressed by the legislature.

The first of these legislative items I wish to suggest for consideration is the need for delegatory authority. In order to encourage a more flexible delivery system and allow for innovations in the utilization of personnel, the state needs to address the existing statutory

exclusivity of licensed functions. There may be a need for a mechanism to allow the legal delegation of functions usually performed by a licensed practitioner, but which may be competently performed by persons in other occupations or with less education, training, or experience. A tremendous overlap necessarily exists in the performance of functions among all levels of health and human services personnel. The opportunity for legal substitution of competent personnel (such as exists in California) should be studied. Our present machinery may also be adequate and is presently being tested.

The second legislative issue is our Human Services Occupations Advisory Council, which has a statutorily mandated membership. At some point, our legislature may wish to consider redesigning this very large body. No provisions have been made to allow representation for newly credentialed groups, and 26 members already constitute a cumbersome number for a policy advisory council. Other design modes that might be considered are lay person or state agency heads.

Another legislative issue for a state considering a model like ours is the overall applicability of the law. I would urge that there be some language defining the groups for whom the decision-making process has been established, as well as specifying legislative intent that all groups go through the process. Discussion should also occur concerning a provision that permits boards and agencies (e.g., departments of Education, Health or Mental Health) that regulate or employ a substantial number of members of the occupational group to have review and approval authority over the registration rules. It may be that to review and advise is more appropriate than the veto power now given.

We made the administrative decision to use subcommittees as the study group. I know that staff investigation would be faster, however, some of the legitimization of the committee might be lost. I don't know which or what combination would be preferred.

There is a growing appetite for reforms in

the occupational credentialing and regulatory areas in both the public and private sectors. Currently involved in one way or another at the federal level are the Congress, the Federal Trade Commission, the departments of Justice, Labor, and HEW, and the Equal Employment Opportunity Commission. I see a lot of evidence that states also are becoming committed to reforms. On the voluntary non-governmental side, there is the new National Commission for Health Certifying Agencies. These efforts will have an impact on public policy during the next few years and this very substantial interest will place even more pressure on the private sector to perform.

There has been much stress on the credentialing arena in the last three years. This was unavoidable, but it has permitted the construction of foundations that are solid enough to stand the test of time. Not everyone can be expected to be pleased by the specific decisions that have been and will be made, or by the detailed process that is involved in arriving at a specific decision. Almost every occupation would prefer to be licensed with an exclusive, self-defined turf. If the health and human services delivery system is to respond to changes in the structure and methods of service delivery, however, this cannot be allowed to continue to occur as it did in the past.

I believe the directions have been set. I believe the tasks are incredibly complex and difficult. I believe as order and credibility are brought to the world of certification, states will have less need to establish separate regulatory systems. Even when they feel they must, they can expect to use the national standards and the national assessment mechanism that the National Commission for Health Certifying Agencies will see are developed. A true public/private partnership is possible.

I would urge all of you to obtain a booklet just put out by your own Council of State Governments, *Occupational Licensing: Questions A Legislature Should Ask*. In addition, if you are interested in the details of our process, its legislation, or its rules, I have

developed a packet of information that is available by writing or calling me at (612) 296-5393.

Health Manpower Planning in the Province of Saskatchewan, Canada

*Donald J. Philippon, Senior Research Officer
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Canada is a federal structure similar to the United States and consists of ten provinces. Provincial governments have jurisdiction over several areas, including health and education. In Saskatchewan, which is a provincial government, we have a Department of Health, a Department of Education, and a Department of Continuing Education. Throughout this presentation, I will refer to the Department of Continuing Education because it has responsibility for all post-secondary education, including the training of health manpower.

Saskatchewan, in terms of area, is comparable to Texas, having some 232,000 square miles. Saskatchewan has a low population density — 3.7 persons per square mile — which creates problems for the delivery of services. Also, over 50 percent of the population lives in non-city areas. There are only seven cities with populations exceeding 10,000 and only two greater than 100,000 — the largest city having a population of 160,000.

We have about 132 hospitals in the province, of which 108 have less than 50 beds and only seven have more than 200 beds. Looking at the major health manpower groups, we have about 1,200 physicians, 4,100 registered nursing positions, and 278 dentists in private practice.

Saskatchewan has been known for several innovations in health care delivery including

Universal Hospital Insurance, adopted in Saskatchewan in 1946 and nationally in 1957; Universal Medical Care Insurance, adopted in Saskatchewan in 1962 and nationally in 1966-67; and the Children's Dental Plan, adopted in Saskatchewan in 1972.

Health Manpower Planning: What Is It? Why Do We Do It?

The World Health Organization, having grappled with the meaning of health manpower planning for some time, came to the following definition:

Health manpower planning is the process of estimating the quantity and type of knowledge, skills, and abilities needed to introduce predetermined alterations in the functioning of a health system so as to make it more probable that the desired changes in the health of a population will be achieved.

In actual fact, meaningful health manpower planning can take place only after the nature of the desired changes in health services and the nature of the desired effects on the health status of a population are known. Clearly, the clarification of roles and skills is extremely important in the case of health care innovations. It is generally recognized that the success of an innovation in health care delivery is largely dependent upon the attitudes and skills of the health personnel involved.

Main Features of The Saskatchewan Approach

There are four features of the Saskatchewan approach to health manpower planning that are particularly noteworthy: close coordination between the health and education sectors; policy formulation and administrative mechanisms; regular and systematic collection of basic data on both manpower supply and demand; and specific strategies to regulate the supply of health manpower.

A key element in the Saskatchewan approach is the close coordination that exists between the health and education sectors — a prerequisite to which is the delineation of the roles of each sector. In Saskatchewan, we have made the education sector responsible for all training matters. To achieve this objective, all hospital-based training programs have been transferred to the education sector.

The responsibility of the health sector is to outline health manpower requirements in terms of quantity and categories. Because health services are very labor intensive, it becomes the responsibility of the health sector to fully consider the health manpower implications of any health care innovation. Thus, health manpower considerations must be an integral part of planning and innovation, not an afterthought.

There are two committees within the province that play key roles in health manpower and development. The first is the Interdepartmental Committee on Health Manpower and Education (ICHME), which consists of the Deputy Minister of Health, the Deputy Minister of Continuing Education, and three other senior officials from each Department. The ICHME is the chief mechanism for formulating policies pertaining to health manpower.

The scope of this committee's deliberations is very broad, including the following areas:

- Health manpower legislation;
- Planning new services;
- Assessing the supply and demand situation;
- Reviewing and setting enrollment quotas;
- and Developing new categories of health

manpower.

While this may seem like just another committee, there are several significant characteristics that probably make this particular mechanism an innovation in itself. First, by involving the highest level of each department, health manpower planning is given a very high priority. Second, the mechanism rests upon a high degree of commitment by each department: decisions reached here are viewed as binding on each department. And third, each department maintains a research and planning unit that conducts all the background research for decision making at the ICHME. Much informal dialogue occurs between these units.

The second committee playing a key role in health manpower planning and development is the Advisory Committee on Medical Education Financing. This committee addresses the traditional position of medical schools where their three main functions — education, service, and research — are frequently funded from different sources.

To develop a more rational approach to medical education financing, that is, an approach that would lead to an orderly development of the medical school, the Province of Saskatchewan in 1977 undertook a study resulting in the establishment of a high-level advisory committee to monitor all funding of medical education. This committee acts in an advisory capacity to both the Ministers of Health and Continuing Education and helps to coordinate financing for all three aspects of medical education.

In addition to the two committees which operate within the province, Saskatchewan participates in several interprovincial mechanisms that contribute to effective health manpower planning. Clearly, no one province or state can develop policies pertaining to health manpower in isolation from what is happening elsewhere. The mobility of health personnel makes this point self-evident.

On the interprovincial level we have developed a forum for discussion on both the national and western regional levels. The Western Canada Health Manpower Committee

consists of a health and education representative from each of the four western provinces and focuses on issues pertaining to that region. On the national level, the Federal-Provincial Health Manpower Committee provides a forum for information exchange.

Another important mechanism in health manpower planning is the use of interprovincial training agreements which have begun to emerge in the past few years. In Saskatchewan, while we employ at least 27 health manpower groups within the province, we only train 17 of these groups. In the other ten areas, we rely on the in-migration of trained personnel. In those areas where a shortage of personnel exists, and where Saskatchewan students have difficulty getting into training programs elsewhere because of enrollment quotas, we utilize interprovincial training agreements.

Under such agreements, a certain number of training spots are reserved for Saskatchewan applicants and the Province of Saskatchewan reimburses the training province for the training costs. Currently, we have such agreements for training in Occupational Therapy, Optometry, and Nuclear Medicine Technology.

A third feature of the Saskatchewan approach to health manpower planning is the regular and systematic collection of basic data on supply and demand. The *Health Manpower Monitoring System*, operated by the Department of Health, collects basic data on the supply and demand situation for some 27 health manpower groups in the province. The system involves twice yearly surveys of all major private and public employers to determine: the number of trained health personnel in the province, the number working, the number of job vacancies that exist, and the extent of job turnover.

The *Graduate Follow-Up Studies*, conducted by the Department of Continuing Education, involves surveys of all non-university health science graduates to ascertain the proportion obtaining jobs and the adequacy of the training programs in preparing graduates for their jobs.

Finally, the Saskatchewan approach to health manpower planning includes some specific strategies to regulate the supply of health manpower. The regulation of *enrollment quotas* is one strategy which I have already mentioned. The central aim is to produce an annual supply of new graduates that correspond to the employment situation in a given year. Most efforts in this regard are directed toward the one- and two-year non-university allied health programs.

The utilization of *student scholarships* with service return commitments is a strategy to encourage students to go into training areas where manpower shortages exist. Three such scholarship programs exist: the paramedical program which is used to support a wide range of groups; the physician program; and the dental program. In meeting their service commitment, graduates must go to areas where vacancies exist. In the case of physicians, accelerated rates of service return are given to persons going into underserved areas.

A strategy designed to directly offset the maldistribution of personnel is the use of *establishment grants*, which is currently employed in the case of dentists. Under the program, dentists can qualify for up to \$20,000 to establish a practice in an underserved area.

The Saskatchewan Dental Plan

One particular health care innovation in Saskatchewan was the result of the health manpower planning process which I have been describing thus far. The Saskatchewan Dental Plan is significant not only in terms of a health service innovation, but also as an innovation in terms of health manpower utilization.

The plan was launched in 1972 to provide restorative and preventive dental services to children between the ages of 3 and 12. The intended age coverage has now been broadened up to 18 year olds. The children's dental plan is being implemented on a phase-in basis,

and as of 1978 it includes all children between the ages of 4 and 12.

The innovative health manpower aspect is the use of a new form of dental manpower, namely dental nurses. I must qualify my remarks by saying that the use of dental nurses on a widespread basis is only innovative from a North American standpoint. New Zealand, for instance, has used a similar type of worker since 1921.

The implementation of the Dental Plan was dependent upon the availability of dental nurses. While immigration was one source, it could not meet the entire need. Therefore, the establishment of a training program in Saskatchewan became a necessity.

Through the mechanism of the Interdepartmental Health Manpower Committee, joint planning as to service and training needs commenced. Within the space of two years, a pilot project was underway, the government decided to proceed with a Dental Plan, and a training program was started. Close cooperation between the health and education authorities must certainly be singled out as a prime factor in the swift implementation of the Dental Plan.

The dental nurse training program, based at the Wascana Institute of Applied Arts and Sciences in Regina, consists of two years of training in the areas of restorative and preventive dentistry. Restorative skills include: amalgam restorations in primary and permanent teeth (fillings); extractions of primary teeth; taking and interpreting x-rays; and placing stainless steel crowns on primary teeth.

But much attention is also given to preventive aspects. There is an emphasis on "teaching" dental health.

The province is divided into six regions and in each region there are school-based dental clinics — some 263 such clinics in total. In each region there is one dentist who supervises about eight teams. Most teams consist of one dental nurse and one dental assistant. The dental nurse operates largely independently, although the dentist is always involved in the initial dental examination of each child and in

the development of a treatment plan.

The enrollment of children in the Plan is completely dependent upon the parents' wishes. To date, over 83 percent of the eligible children have been enrolled. In 1978-79, the Dental Plan will be covering all 4 to 12 year olds with a total approved staff consisting of 20 dentists, 182 dental nurses, and 204 certified dental assistants.

Looking at the quantity of services provided, in 1976-77 some 59,000 children received services from the plan. On the average, 2.2 fillings were performed per child. As well, much attention was given to both group and individual nutritional counseling and oral hygiene instruction.*

In implementing the plan, we have steadily moved the initial coverage age downward because of the critical nature of the early years. For instance, our records indicate that the average six-year-old child, who has not had prior coverage, already has four decayed teeth.

The dental profession both in Saskatchewan and elsewhere has frequently expressed reservations about the quantity and quality of the services provided. To assess the quality of services, the heads of three Faculties of Dentistry were commissioned to undertake a study in 1976. The study† included children who received dental care from dentists in private practice. The conclusions of this study are most encouraging — note the following:

On the basis of the 410 children examined and the 2,107 amalgam restorations evaluated, amalgam fillings placed by the Saskatchewan dental nurses, on the average, were better than those placed by dentists.

On the basis of 97 stainless steel crowns evaluated, there was no quality difference between those placed by dentists and those placed by dental nurses.

* Saskatchewan Dental Plan
1978 *Annual Report, 1976-1977*.
Saskatchewan Department of Health

† Ambrose, E.R., A.B. Hord and W.J. Simpson
1976 *A Quality Evaluation of Specific Dental Services Provided by the Saskatchewan Dental Plan*. Saskatchewan Department of Health.

The combined quality and coverage of the care achieved by the Saskatchewan Dental Plan after nearly two years of preparation is impressive.

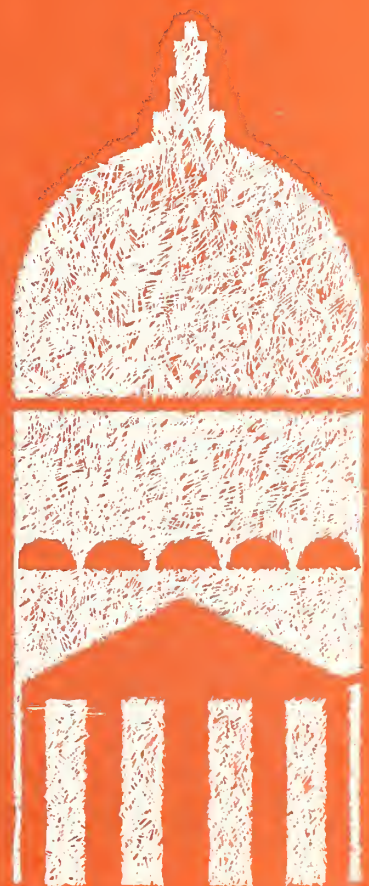
I must point out that the quality evaluation looked only at restorative aspects. We believe that the ultimate success of the dental plan is dependent upon the impact of the program's prevention emphasis — will public attitudes really be changed towards dental health or will the dental plan simply become known as a "drill and fill" program?

It is still too early to assess the effectiveness of the Dental Plan in changing attitudes toward dental health, but there are some encouraging signs. For instance, the frequency of recalls for further maintenance work is lower than what was originally expected.

Finally, the costs of the Dental Plan are interesting. The average cost per enrolled child has been falling — from \$158 in 1974, to \$108 in 1975, and to \$84 in 1976. We now believe that the costs are less than the cost of comparable services in the private sector.



**IV. STATE HEALTH
INSURANCE PROGRAMS:
NHI GROUNDWORK
OR ALTERNATIVES?**



Health Insurance

National health insurance has been a perennial issue throughout the 1970's. Yet as the decade closed, the United States remained without a comprehensive health insurance plan for all its citizens. Nevertheless, several American states began their own programs to cover the catastrophic health expenses of their citizens. In addition, Canada and especially several Western European countries have accumulated significant experience with national health insurance programs. Each of these programs may have significant lessons for other state and federal policymakers.

William Glaser warns that policymakers, whatever their ideological bent, should not lose sight of the fact that national health insurance is simply a different method of paying for health services. Moreover, he believes it is a method of payment that can accommodate a variety of delivery systems.

After examining the national health insurance structures adopted by other Western countries, Glaser — a professor at Columbia University — is optimistic about American provider groups' acceptance of NHI. He believes that physician participation in the United States will present no problem. In fact, viewing providers as powerful groups that must be dealt with by the government, Glaser suggests that these groups may actually profit from the transition to NHI. In his opinion, the government will willingly concede certain points to providers in order to win their initial cooperation and goodwill.

Glaser also argues that NHI is not inherent-

ly costly or inflationary. "That would occur," he says, "only if carriers and government were weak bargainers in negotiating with doctors, hospitals, and drug companies." He notes further that NHI would, in its structural organization, present specific points where costs could be checked, in contrast to the present "amorphous" situation in the United States.

Glaser is hesitant to designate an initial NHI plan, however, as the final structure for financing health care delivery. Indeed, he points out that based on demographic trends, NHI experience in other countries "fore-shadows problems in its ultimate viability." With the number of intensive users of health care increasing at a faster rate than the taxpayers and wage-earners that support the current system, several European countries are already finding their health insurance accounts in trouble. Ultimately, Glaser anticipates that NHI will serve as an intermediate step for these countries, resulting in an eventual change in financing insurance from premiums to general revenue payments, or replacing insurance with a national health service. But the unavoidable issue that must be addressed, according to Glaser, is how are health care services to be rationed.

Lessons about government-funded insurance programs may be learned from the states, as well as from other countries. Seven states now either require that commercial insurers offer a minimum health insurance benefit package, offer a state health insurance program (usually

for catastrophic illness), or provide a combination of both. Maine, Rhode Island and New York (still in the experimental stages) have state catastrophic illness programs that provide incentives to purchase good commercial coverage and that assume paying for health services once those commercial third-party benefits are exhausted. Hawaii, on the other hand, requires that a comprehensive, prepaid health insurance program be offered by employers to all employees. Other states with various kinds of plans include Alaska, Minnesota and Connecticut.

Maine's Catastrophic Illness Program was enacted in 1974, together with a Medicaid Medically Needy Program. (The latter program is similar to that of 20 other states and provides Medicaid benefits to persons with incomes in excess of the poverty level.) Ronald Deprez of the University of Maine reports the findings from a first-year evaluation of both the Catastrophic Illness Program and the Medically Needy Program.

Maine's catastrophic illness program will pay for health care expenses after an applicant spends a \$1,000 out-of-pocket deductible and meets an additional 20% "spend down" stipulation. Deprez notes that the spend down provision requires an applicant to spend 20 percent of his before-tax income on health care expenses — a well-acknowledged special hardship on low-income applicants. Legislative attempts to remedy this inequity have failed because of feared expenditure increases. The Medically Needy Program, however, with its 70 percent federal/30 percent state funding ratio, was implemented to ameliorate some of these problems for low-income residents.

State financing for both the catastrophic and medically needy programs has been inadequate. Both programs have been funded by a two cents per package state tax on cigarettes. Deprez expects that another form of financing will have to be arranged to avoid fund depletion in the near future.

New York's catastrophic illness program is designed specifically to protect a family's assets and sources of income and to avoid

forcing applicants into near impoverishment. State Senator Tarki Lombardi explains that their program was structured to allow family members to receive needed medical assistance while the primary wage earner stays productively employed. Too often, Lombardi adds, rigid Medicaid or welfare eligibility criteria had forced applicants to leave employment in order to receive financial assistance.

Enacted in 1978, the New York Catastrophic Health Care Expense Program will be funded with 50 percent federal funds together with an HEW Medicaid waiver for the state's pilot programs. Lombardi emphasizes that this program will place no limitations on age, income or assets, but will make assistance available to anyone incurring catastrophic health care expenses. If successful in its two pilot locations, the program would then be expanded statewide. Unfortunately, however, as of late 1979 DHEW still had not granted a waiver to begin covering catastrophic illnesses for working individuals in the two pilot counties identified by the state.

Rhode Island's Catastrophic Health Insurance Program (CHIP), enacted in 1974, incorporates incentives for residents to purchase adequate health insurance coverage. Brian Keeler, chief of the State Division of Health Insurance, explains that it is the scope of the applicant's private insurance policy that determines the amount of the CHIP deductible to be matched. The closer the private policy resembles the CHIP "qualified plan," the lower the applicant's deductible. There are six levels of deductibles in Rhode Island, ranging from \$500 to \$5,000. An applicant is eligible for benefits under CHIP whenever his health care expenditures equal either the designated deductible for the type of insurance he purchased, or the designated percentage of allowable income spent for health services (a 10-50% spend down), whichever is greater.

After all spend down and deductible requirements are met, CHIP pays not only medical but also mental health expenses. This includes full reimbursement for inpatient mental health services and 50 percent reimbursement for out-

patient psychiatric services.

These latter benefits are currently under review, Keeler notes, because for FY 1978, 27 percent of the program's expenditures went for mental health benefits.

Summarizing his state's experience, Keeler highlights Rhode Island's utilization of existing state agencies and fiscal intermediaries for the plan's implementation and administration. He also notes that through the CHIP enabling legislation, the state managed to assist floundering HMOs. By requiring all employers to offer a dual choice/HMO option, Keeler believes the state was able to strengthen local HMOs which, in the past, had been repudiated by local employers.

In 1974, the Hawaii state legislature took a different approach to assuring payment for the health care expenses of its citizens. It enacted a mandatory, comprehensive, prepaid health care program based on health insurance coverage through employment. Reaction to the Prepaid Health Care Law, State Senator Donald Ching remarks, "was not the hue and cry that one might expect considering the novelty of the concept."

Under this new Hawaii law, employers are required to pay at least 50 percent of their employees' health insurance premium, while employees contribute no more than 1.5 percent of their monthly salary. An employer can offer plans that either reimburse for services or provide services directly. In either case, minimum standard benefit packages, patterned after existing HMO and Blue Cross/Blue Shield plans, are specified by law. Ching points out that adoption of prevailing benefit packages easily established a "floor" for benefits and services with minimal disruption and maximum acceptance.

Ching believes that Hawaii's program benefited from centralized administration and extensive utilization of existing agencies. New program responsibilities, for example, were smoothly integrated into the Disability Compensation Division of the State Department of Labor and Industrial Relations. He explains that three important state mandated employee

benefit programs — Workers' Compensation, Temporary Disability Insurance, and Prepaid Health Care — have been placed under one administrative umbrella.

As a result, the health insurance program in Hawaii imposed only minimal costs on the state — costs for administration and for premium supplements generated by the limitation imposed on employee contribution. As Ching phrased it, "Much to our pleasant surprise, the administrative expenses . . . have been comparatively low."

National Health Insurance in Practice

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Americans say they are about to enact national health insurance, but they are not clear as to what it really is. Since the United States is the world's last developed country to enact national health insurance, the subject should not be so mysterious and confusing. America need only look at the many other countries that have long had a national health insurance system, in order to learn how to design one, or even if any of Washington's anxieties about national health insurance are vindicated.

The Difference to the Patient

National health insurance is simply another way of paying doctors, hospitals, and other suppliers of health services. In almost every country both inpatient and ambulatory care are covered benefits and all — or nearly all — citizens are covered. Usually, a national health insurance program makes official, as well as expands, the forms of medical care delivery that had been in existence earlier.

The typical patient, therefore, gets the same types of benefits that were enjoyed earlier, such as office care by doctors, hospitalization, drugs, and some prostheses. But these benefits are paid for differently, since national health insurance is supposed to be an improved system of reimbursement. Coverage of benefits is standard for large segments of the population

and is commonly known. If the patient is expected to pay any costs, both the patient and the provider generally know this in advance.

National health insurance tends to level payments; that is, the rich patient is rarely more profitable to doctors and hospitals than the poor patient. Gradually, reimbursement rates in rural areas approach those in the biggest cities. As a result, access to health care services becomes more equitable. In many countries, national health insurance laws promise to provide the patient with the full list of benefits. Therefore, governments, medical associations or insurance carriers try to place doctors and facilities in underserved areas.

The Difference to The Doctor

American doctors warn against adoption of a national health service that would impose government controls over them. But "national health insurance" is not a "national health service." The latter is a method of employing nearly all doctors, often — but not always — on salaries. Examples of these systems are found in Great Britain and Sweden.

But national health insurance itself is merely a method of payment. As in the enactment of any public policy, a political deal is struck between the medical profession and government: in return for the doctors' cooperation, the method of health care delivery is not altered. Doctors remain in office practice, if they wish. Hospitals stay in voluntary hands, if that is the custom. Patients and doctors are

guaranteed free choice, and government is limited to setting rules and collecting money.

Since national health insurance is a public program that requires predictable budgeting, each doctor must follow certain rules. In particular, his charges must follow a fee schedule. However, the rules and fee schedules are not imposed unilaterally upon the doctors by government. Rather, they result from collective bargaining between the medical association and the health insurance carriers.

Doctors profit financially, instead of losing. During the first years of national health insurance, the health insurance carriers and the government try to "buy" the profession's cooperation by leveling all fees up to those collected by the higher-priced physicians. And in contrast to private practice, all bills are collected in full.

In countries with national health insurance, no doctor is required to practice under the national health insurance scheme. All have the right to practice privately and continue to collect private payments. However, only a few specialists in the principal cities can prosper in this way. All others take national health insurance practice as a matter of course.

The Difference to Hospitals

Countries have not settled on any standard method of managing and paying for hospitals, comparable to the nearly universal practice of paying office doctors for ambulatory care under fee-for-service. Usually the owners of hospitals are local rather than large nationwide agencies. In some countries, hospitals are owned by provincial or local governments. In other countries, private charitable associations own a large proportion of them. Throughout the world, governments are beginning to plan and control new construction and the acquisition of new machinery, on the grounds that it is the governments that pay for the buildings and equipment. Often the national government leads the planning efforts.

Countries are experimenting with various methods of paying for hospital operating

costs. Many have government agencies that inspect and approve hospital operating budgets for the next year. In a few countries, hospital insurance is paid out of public funds, and governments pay operating costs in full. Where insurance carriers exist, they pay operating costs for their subscribers' inpatient or outpatient care, and the provincial, national, or local government pays the rest of the operating costs.

The Difference to Government

Since most national health insurance does not create government agencies that employ doctors, it is not a conventional public program that shows up in government budgets. Rather, it is administered by those in an "autonomous" sector, such as health insurance carriers, medical associations, and similar nongovernmental — but public — agencies in other areas of the social services. These organizations act according to law; they receive payroll taxes levied on subscribers and employers, much like the premiums in the pre-existing private insurance; and they pay benefits.

Some Americans are worried that national health insurance will produce large deficits in government budgets. But it would do so only if Washington added many new benefits and changed the current financing method. All transactions that now pass through many collectors and payers of money would pass through a single structure of payroll taxes, carriers, and payments according to fee schedules and rate schedules. If the law required the carriers to limit payments to their incomes from payroll taxes, large government subsidies from general revenue would not be necessary.

Some Americans fear that national health insurance will feed inflation in health costs. That would occur only if carriers and government were weak bargainers in the negotiations with doctors, hospitals, and drug companies. The organized structure of national health insurance provides decision points where costs can be checked, in contrast to the present amorphous situation in the United States. The

proportion of Gross National Product now going into health care in the United States (about nine percent) is one of the highest in the world. During the 1970's — except for two years of wage and price freezes — the proportion rose faster in the United States than in any country with national health insurance. Canada and Germany demonstrate the possible savings from strictly administered national health insurance. During recent years, the proportion of these countries' GNPs spent on health has remained almost the constant. In Canada the figure occasionally has dropped.

The Difference for Insurance Carriers

A significant change under many national health insurance programs is the growing independence and importance of insurance carriers. Nonprofit private health insurance funds have continued under national health insurance in most countries as official carriers. Their previously private premiums were converted into payroll taxes, levied on subscribers and (usually) on their employers. These taxes become part of the flow of social security money from subscribers and employers to the providers of services.

The carriers become watchdogs of the system. They bargain with medical associations over contracts and fee schedules. They argue for lower rates before the agencies that determine payments to hospitals. They speak for subscribers in demanding adequate performance from doctors and hospitals.

If the United States follows foreign precedents, Blue Cross and Blue Shield would probably merge and become the carriers under national health insurance. The for-profit insurance companies might not play a role. Abroad, the work is either legally confined to the nonprofit carriers, or the private companies find health insurance unprofitable. The Blues would have to develop their foreign counterparts' style of adversarial bargaining with providers; therefore they would have to exclude representatives of the doctors and of

hospitals from their governing boards.

The Future

National health insurance will not be the final form of organizing health financing. The demographic trends of developed countries foreshadow problems in its ultimate viability. It is not conventional insurance, with benefits paid from the subscriber's investment, but (like all social security) it is a pay-as-you-go system: current subscribers, employers, and taxpayers pay for the bills of current patients. In all developed countries, the retired and the invalids (who are heavy users of health care) are increasing at a faster rate than the wage-earners (who pay premiums and taxes). Several European countries — Germany, France, and Switzerland — are far along in these trends, and their health insurance accounts are seriously strained. During the late 1970's, European policymakers were engaged in desperate patchwork to restrain rising costs and to subsidize the accounts.

Eventually, most countries will need to change from premiums to general revenue payments into the insurance accounts (as in most of Canada), or replace insurance by a national health service (as in Great Britain and Sweden). Ultimately, policymakers in the United States and elsewhere will have to face the hardest of all choices in a utopian field: How to ration services to the "needy." If Americans can make their difficult decision to introduce national health insurance during the coming years, they will be buying time, with even harder choices ahead. But meanwhile, they will have created a system for identifying the problems and for making decisions. And that can be the most valuable lesson the United States can learn from abroad.

Many (but not all) of the foregoing points are elaborated in the following publications:

Paying the Doctor: Systems of Remuneration and their Effects (Baltimore: The Johns Hopkins Press, 1970).

Health Insurance Bargaining: Foreign Lessons for Americans (New York: Gardner Press and John Wiley, 1978).

The Doctor under National Health Insurance: Foreign Lessons for the United States. A report to the Office of Research and Statistics, Social Security Administration, 1977. Available from the National Technical Information Service, Springfield, Virginia; and from the national Health Planning Information Center, Hyattsville, Maryland.

"Socialized Medicine in Practice," *The Public Interest*, Volume 1, Number 3 (Winter 1966), pp. 90-106.

The Maine Catastrophic Illness Program

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In 1974, the Maine Legislature passed L.D. 2535 creating the catastrophic illness program (22 MSRA 3283). The intent of the legislature was to establish a health program that would make it impossible for individuals to experience financial catastrophe as a result of the expenses associated with certain types of medical care.

The statute establishes a formula governing eligibility and defining catastrophic illness in terms of financial expense. The formula requires (1) that before eligibility is determined and aid granted, all applicable health insurance benefits and liability benefits must be applied to incurred costs; (2) that an applicant must pay certain medical expenses in excess of specified limits before becoming eligible for catastrophic illness aid (The latter is the "spend down" requirement. It stipulates that 20 percent of a person's income before taxes must be applied to the costs of care and that 10 percent of his net worth, if his net worth is in excess of \$20,000, must also be applied.); and (3) that after conditions (1) and (2) are met, assistance will be given only for medical costs in excess of \$1,000 (the \$1,000 deductible).

Coverage in the Catastrophic Illness Program includes expenses for hospital inpatient and outpatient services, physician services, skilled nursing facility services, ambulance

services, home health services, drugs, appliances and other related services as determined by the Department of Human Services. Initially, the Department designated dental services as a covered benefit, but dropped it in 1977.

The law set the first-year state appropriation for the program at \$2.8 million, to be raised by an increase in the cigarette tax of two cents per pack. The cigarette tax increase was not set aside as a special revenue account, but deposited in the General Fund from which the appropriation was drawn. The legislature did stipulate, however, that any remaining balance in the catastrophic illness budget be carried forward to the next fiscal year.

Background of the Legislation: Two Programs for the Price of One

Maine's Catastrophic Illness Program was prompted by the personal experience of Governor Ken Curtis, whose two daughters were afflicted with cystic fibrosis, a terminal illness. The high medical bills, in Curtis' case, were mostly covered by insurance. However, he gained unique insight into the effects of catastrophic illness on families without adequate insurance coverage.

When Curtis became governor of Maine he introduced, with the help of House Speaker John Martin, the Catastrophic Illness Program legislation into the regular session of the 106th Legislature. The legislative struggle for its enactment centered primarily around the program's costs and who would benefit. Because

there was no accurate way to predict costs, estimates were extremely disparate. To reduce some of the uncertainty, a \$1,000 minimum was included in the bill as a prerequisite deductible. This upset some of the bill's more liberal supporters, who were concerned that poorer individuals not qualifying for categorical assistance under the Medicaid program also would not qualify for this new proposed program — although a \$1,000 worth of medical bills would constitute a catastrophe by their income standards.

The result was a legislative compromise initiating not one, but two programs in Maine: the Catastrophic Illness Program (the wholly state-financed program described above) and the Medically Needy Program. The latter program is an optional feature of Medicaid, funded in Maine on a 70/30 federal/state match. It covers families and individuals who meet AFDC and SSI criteria as categorically needy, but who are ineligible for assistance because of excess income and/or other resources. Generally referred to as "categorically related needy," these individuals can receive federal assistance for medical services but cannot receive money payments. As a result of adopting this Medicaid option, Maine receives considerable federal financial aid to help persons who might otherwise fall under the Catastrophic Illness Program at 100 percent state expense.

Interestingly, there is no mention of the Medically Needy Program in the law creating the Catastrophic Illness Program. Instead, it resulted from a legislative understanding that

revenues raised by the additional two cents cigarette tax would be used to fund both additional Medicaid expenditures and catastrophic illness expenditures.

Program Implementation and Revision

As is typical of most states, once a bill becomes law there is very little systematic follow-up by a legislature in regard to implementation. This was one reason why the Health Policy Analysis Project began to perform oversight and evaluation for the Legislature.

One of the tasks during the Health Policy Analysis Project's first year of operation was to evaluate the impact of both the Medically Needy and the Catastrophic Illness Programs. Some of the highlights of the Health Policy Analysis Project report on these programs, including subsequent legislation, are as follows:

- The Catastrophic Illness Program is effectively serving those people who incur, in an absolute sense, enormous medical bills. For example, among those whom the program has benefited are individuals whose bills have been as high as \$90,000.
- Overall costs have increased more than threefold since the beginning of the program. Client use, however, did not increase substantially until the last fiscal year (1978), when there was a 103 percent increase.
- Total per capita costs have changed very little in the first four years of the program,

Table 1. Catastrophic Illness Program, Costs and Client Use

Overall Costs			Cases		Per Capita Costs	
Total Amount		% Change	Number	% Change	Total Amount	% Change
FY 75	\$457,195	—	629	—	\$727	—
FY76	\$663,240	45%	674	7%	\$984	34%
FY 77	\$806,116	22%	722	7%	\$1,118	14%
FY 78	\$1,418,432	76%	1,464	103%	\$988	-11%

actually declining between FY 77 and FY 78.

The costs and number of cases in the Catastrophic Illness Program for the first four years of its existence are shown in Table 1 below.

We have learned a number of other things from our four-year experience with the Catastrophic Illness Program in Maine. One important lesson is that spend down requirements — 20 percent of pre-tax income, and 10 percent of net worth if over \$20,000 — appear reasonable for those persons whose income is above \$15,000. Persons with low incomes, however, must apply a proportionately higher percentage of income to meet spend down requirements than persons with higher incomes. For example, a person with an income of \$4,000 must incur bills in excess of 45 percent of his income in order to qualify, while a person with an income of \$15,000 is required to spend down approximately 26 percent of his income.

Because the present catastrophic illness program has a flat deductible and defines catastrophe in terms of medical expense, it fails to take into account the financial burdens imposed by illness on low-income groups. This is particularly true for families who do not meet AFDC criteria, or persons who are not blind or disabled and between the ages of 21 and 65, but still have low incomes. They cannot qualify for Medicaid as categorically related, and must incur relatively heavier expenses to enter the Catastrophic Illness Program than wealthier families and individuals. Officials state that the present catastrophic illness program is not providing relief from financial catastrophe for low-income persons with medical bills equal to a large percentage of their income, but less than the spend down requirements.

In the 1978 session of the Legislature a bill was introduced to change the spend down requirement to a flat 25 percent of the client's income. This bill would have equalized the definition of catastrophic illness for all income levels. This section, however, was not enacted

because it was thought that the additional increase in expenditures would exceed the program's revenues.

The legislature did pass some amendments to the Catastrophic Illness Program, however. These new provisions would protect a person who was financially responsible for two or more people from having to meet spend down criteria for more than one person during any 12 month period.

The Medically Needy Program: Additional Assistance for the Poor

The Medically Needy Program was instituted concurrently with the Catastrophic Illness Program so that the state could take advantage of available federal funds. Under the state's current Federal Medical Assistance Percentage (FMAP), 70 percent of the Medically Needy Program is financed by federal revenues matched by 30 percent from the state. (FMAP's vary with each state and have an inverse relationship to state per capita income.) The program covers those families and individuals who meet AFDC and SSI criteria as categorically needy, but are ineligible for such assistance because of excess income and/or resources.

There are two basic federal regulations governing eligibility for the Medically Needy Program. First, a person's income level must be within 133 1/3 percent of the state's AFDC cash payment level for a family of the same size. Second, eligibility for the program lasts six months, and is renewable; eligibility may also be retroactive for three months, if certain criteria are met. A key provision under Maine law requires that excess income, amounting to more than \$1,150 for one person, \$2,250 for two people, or \$2,250 plus \$100 for each additional family member, must be applied as spend down before a person can become eligible for medically needy coverage.

Unless the state wishes to pay for optional Medicaid services, the mandatory services covered under the Medically Needy Program are the same as those required under the categorical program.

Total expenditures and client use for the Medically Needy Program are shown in Table 2 below. These figures indicate there has been a significant increase in expenditures and number of cases in the Medically Needy Program. Strangely enough, however, per capita costs dipped markedly last year.

Administrative Problems

While the Catastrophic Illness Program has been working fairly smoothly, the Medically Needy Program has been faced with a number of problems, most of which stem from understaffing. Application decisions, for example, often had exceeded the federally mandated 45-day limit. A recent Maine law attempts to remedy this problem by requiring that temporary medical cards be issued once the 45-day limit expires.

Additional caseload burdens and delays have been caused by applicants who clearly do not meet the spend down and medical expense criteria. To remedy this problem, the Department of Human Services is currently devising a procedure to notify these ineligible applicants at an early stage of their application. In addition, recent legislation has mandated design of a procedure to transfer certain recipients from the categorically needy programs to the Medically Needy Program.

There are currently 27 1/2 people working on a total of 11,500 cases in the Medically Needy and Catastrophic Illness Programs. Only 12 of these people are officially assigned to the programs. The remaining 15 1/2 are borrowed from other programs within the Department of Human Services. With the

numbers of people enrolling in both programs increasing, it seems obvious that both programs are critically understaffed. This situation will have to be rectified soon in order for them to operate efficiently and effectively.

Initial state appropriation for both programs was set at \$2.8 million state dollars, to be raised by a two cents per pack increase in the cigarette tax. Actual state revenues and expenditures for both programs are shown below.

Revenues and Expenditures

(in Millions of Dollars)

Fiscal year	Revenues from 2¢ per Pack Cigarette Tax	State Expenditures for Catastrophic and Medically Needy Program
1975	\$2.95	\$0.46
1976	\$3.06	\$1.05
1977	\$3.10	\$1.64
1978	\$3.05	\$2.92

The difference between expenditures and revenues has been dwindling rapidly. With an ever-increasing number of applicants, it is expected that these programs will face a deficit in the next fiscal year. Excess funds from previous years should be able to cover this deficit. It seems apparent, however, that Maine will have to somehow increase its revenues for these two programs in the next couple of years if their financial visibility is to be maintained.

Table 2. Medically Needy Program, Costs and Cases

Costs				Cases		Costs Per Capita	
	Total	State Costs	% Change	Number	% Change	Costs	% Change
FY 76	\$1,270,230	\$390,000	—	3,189	—	\$398	—
FY 77	\$2,810,417	\$840,000	121%	4,077	28%	\$689	73%
FY 78	\$4,991,333	\$1,497,400	78%	10,047	146%	\$149	-78%

New York State's Catastrophic Health Care Program

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New York*

Like state legislators elsewhere, many of us in New York long have been concerned with the problems of families whose incomes are above the poverty level but who still need assistance for catastrophic health expenses. Under Medicaid, families are forced to meet rigid income and resource requirements — too often forcing the primary wage earner to leave employment so that the family may receive a public assistance grant and medical assistance.

Confronted with these problems, New York State enacted major legislation in 1978 to end the requirement of near impoverishment before state assistance could be provided. Though still of an experimental nature, the clear intent of the law is to eventually permit a family to obtain assistance in meeting medical expenses clearly beyond its ability to pay. Before adopting this approach statewide, however, New York is attempting to obtain a Medicaid waiver to experiment with the program in two upstate counties, one rural and one urban, that exhibit typical population patterns. If these experiments prove successful, the plan would then be adopted on a statewide basis.*

If adopted statewide, the law would not replace Medicaid. Instead, it would provide

benefits to those persons who cannot meet Medicaid standards but whose private health insurance benefits have been exhausted. All services covered under Medicaid, however, with the exception of residential care, would be reimbursed for eligible families.

When implemented, the New York program will place no limitation on age, income or assets. Families would not be forced to use all available assets prior to becoming eligible. This means that savings would not have to be depleted, life insurance policies liquidated, or property sold. Instead, eligibility for assistance is related solely to family income and health care expenses.

Under the statutory formula, catastrophic expenses would be shared between the family and the state once they exceed a deductible. The deductible is computed at 50% of the difference between family's income and the state's basic public assistance grant. As shown in the two examples below, this results in state payments to low income families with far less costly (but not necessarily less catastrophic) medical expenses.

The law will permit the Commissioner of Health to establish a "cost-sharing" formula for sharing expenses once the deductible has been reached. In addition, once medical expenses exceed 75% of the family's available income, the state would pay all expenses.

Unlike Medicaid, the New York Catastrophic Health Care Expense Program will not reimburse providers directly in most situations. Instead, payments will be made retro-

* Editor's Note: As of late 1979, New York still had not received a waiver and the demonstration programs were not in effect. Some state officials believed DHEW purposely slowed the waiver process because state efforts might detract from federal efforts for national health insurance.

actively to the family in the year after eligible medical expenses are incurred. A "hardship" provision, however, permits the state to reimburse providers directly in unusual instances. The latter provision does not alter eligibility criteria, and the state would pay only its portion of expenses under cost-sharing.

Part of the law's intent is to encourage employers and families to purchase comprehensive health insurance coverage. As a result, all health insurance premiums, including those paid for by an employer as well as by the family directly, are included in the definition of medical expenses. This means that in the example of the family of four with an income

of \$15,000 (Family I), as much as 25% of the total deductible of \$4,307 will have been spent on ordinary health insurance premiums — if the family has good health insurance coverage in the first place.

If eventually authorized, the New York catastrophic law would be implemented with the assistance of the state's local social services districts. These districts, which also authorize most welfare and Medicaid spending in New York, would be permitted to authorize interim payments for those families incurring the deductible before the calendar year expires. Medical expenses would be paid at the rate authorized for Medicaid services.

Family I (4 Individuals)

Total family income	\$15,000
Imputed Fed. income tax	<u>-1,385</u>
Available balance	13,615
Public assistance level	<u>-5,000</u>
Available income	\$ 8,615
50% of available income (deductible)	\$ 4,307

Family II (4 individuals)

Total family income	\$ 6,500
Imputed Fed. income tax	<u>0</u>
Available balance	6,500
Public assistance level	<u>5,000</u>
Available income	\$ 1,500
50% of available income (deductible)	\$ 750

The Political Planning of a State Health Insurance Program in Hawaii

*Sen. Donald D.H. Ching
Majority Leader
Hawaii State Senate*

The concept of prepaid health care based on mandatory, employment-related coverage was a brand new idea when first introduced in the Hawaii Legislature in 1971. Three years later it became law as Act 210 of the 1974 legislative session.

Enactment of our Prepaid Health Care Law climaxed several years of lively discussion in the Legislature. For many of us who supported it, Act 210 marked yet another milestone in the growing body of progressive legislation placed in statute since our Islands became a sovereign state in 1959.

Measured against the national background, the law represented a significant achievement in terms of social progress. Yet, while there was much discussion between introduction and enactment, the proposal was not widely viewed as politically controversial by the public at large. As a matter of fact, in my nearly 20 years of experience in our Legislature, I have seen a lot more heat generated over issues of considerably lesser public import.

The Prepaid Health Care Law required virtually every employer in the state to provide regular employees with a health insurance program and to contribute at least one-half of the premium cost for the employees' coverage. The major categories of employees excluded are insurance and real estate salesmen paid entirely by commissions and individuals under

21 working under a parental relationship.

The employee's contribution to the health insurance program may be no more than 1.5 percent of his monthly salary. A "regular" employee is defined as one who works at least 20 hours a week, excepting seasonal workers in Hawaii's pineapple industry.

Health plans negotiated under collective bargaining agreements are exempt because such negotiated benefits are, for the most part, either more liberal in coverage or necessitate larger employer contributions than are required under the Act.

An employer can elect to provide a plan that obligates the insurer either to reimburse for the expenses of health care services or to directly furnish the required health care. The level of benefits provided must be equal to, or a medically reasonable substitute for, those benefits that are provided by prepaid health care plans of each type (i.e., those reimbursing for services or those directly providing services) that have the largest number of subscribers in the state. In the case of reimbursement plans, the standards are based on the Hawaii Medical Service Association's Plan IV (Blue Shield). Standards for direct provision of service plans are based on the Kaiser Health Foundation Plan I. Both the Hawaii Medical Service Association's Plan and the Kaiser Plan are basic, comprehensive medical plans emphasizing ambulatory care.

Other insurance plans may be offered by the employer to fulfill the law's mandate. These alternate plans must undergo review and approval by a seven-member advisory council,

comprised of consumer, employer, medical profession, and health care plan representatives, that judges whether the alternate plans are reasonable substitutes for state standards.

What kind of coverage is required by our law? Every qualifying plan must include the following:

- 120 days of hospital benefits, plus outpatient services;
- surgical benefits, including anesthesiologist services;
- medical services, including home, office, and hospital visits, intensive medical care;
- maternity benefits, provided an employee has been covered for nine months prior to childbirth; and
- substance abuse benefits for alcoholism and drug addiction, including outpatient services, detoxification, and acute-care benefits (required by a 1976 amendment).

Given Hawaii's history of progressive social legislation, it appeared logical to move toward some form of a mandatory prepaid health care law. The question was how best to extend coverage to the uninsured working men and women of Hawaii, and thereby provide them "equal treatment" as a matter of social equity. Moreover, how could this be best achieved without any substantial added costs to the state — bearing in mind that there is little reliance on local taxation in our centralized system, which therefore imposes unusually heavy financial burdens on the state.

To determine cost factors and the numbers and classes of employees in the uncovered "gap group," a study was commissioned through the Legislative Bureau, the Legislature's principal research arm.

This study, the Reisenfeld Report published in 1971, was thorough and comprehensive. Acknowledging the difficulty of precisely quantifying need, the report generally concluded that, among the state's employed, 11.7 percent did not have hospital coverage, 13.5 percent lacked surgical coverage, and 17.2 percent did not have regular medical insurance.

There was very little question as to whether the plan proposed would be comprehensive or catastrophic in its approach. The Reisenfeld report recommended the comprehensive coverage plan and specifically recommended adoption of prevailing coverages in the state, which then became the legal minimum. Prevailing coverages reflected the health care habits and patterns of state residents and set a "floor" without unduly disrupting the existing schedules of coverage.

The decision to make coverage mandatory was central to the legislation. Before enactment of Act 210, voluntary participation was, in effect, the public policy of the state.

As to the question of affordability, the only new costs imposed upon the state resulted from the administrative requirements of the law and anticipated premium supplementation.

Administration of the new program proved to be quite easy, and it smoothly meshed with existing responsibilities of the Disability Compensation Division of the State Department of Labor and Industrial Relations. Thus, three important employee benefits programs were placed under one umbrella: the well-established Worker's Compensation Law, the Temporary Disability Insurance Law passed in 1969, and the Prepaid Health Care Act enacted in 1974.

Much to our pleasant surprise, administrative expense resulting from Act 210 has been comparatively low. Initially, we authorized 11 new positions in the Disability Compensation Division, with an appropriation of \$250,000 in General Funds to cover salaries and other expenses. To the division's credit, Act 210 was implemented with substantially the existing staff. After the first appropriation lapsed, it was renewed in 1977 at the same annual level on the expectation that additional personnel would be recruited during the next biennium. Salary costs for the 1977-78 biennium amounted to \$188,000. For the current fiscal year, with all 11 positions filled, staff costs are projected to be \$244,000.

Because of statutory limits imposed on employee contributions for the health insurance coverage, an important feature of Act

210 is the provision to assist employers with increased insurance costs by means of a premium supplement financed by the state. This provision of the law, partially subsidizing employer contributions, was included to give cost protection for marginal small businesses. Initially, \$375,000 was set aside in a trust fund for premium supplementation. Again to our surprise, there had been little need to supplement premiums. To date, only about \$25,000 has been tapped from the trust fund for subsidies.

What are the numbers that actually surfaced as a consequence of Act 210? The division reports that 20,340 employers have been registered thus far. However, the extent of newly covered workers has been difficult to establish because many of the registered employers had voluntary programs in effect before Act 210. Dr. Riesenfeld, the author of the original study, estimated that some 40,000 employees were not covered at the time he completed his report. The Disability Compensation Division is of the opinion that more than 40,000 persons actually received new benefits because of the requirement that employers cover at least half of the premium costs.

Of the 20,340 employers now registered, all but about 1,000 have elected plans offered by the state's two major insurers — the Hawaii Medical Service Association and Kaiser. The approximately 1,000 employers who have opted for plans offered by other insurers are the major source of additional workload upon the division. Each submittal in this category must be reviewed by the advisory council for equivalency with the minimum benefits established by the law.

Thus far, I've given you mostly good news about Hawaii's experience with its innovations in health insurance. Let me briefly cover the one major problem we have run into.

The only fly in the ointment so far has been with the federal Employees Retirement and Income Security Act (ERISA) or, more precisely, with the interpretation of ERISA by one employer in Hawaii. This employer, Standard Oil of California, operates a refinery

and distributes petroleum products in our state.

At the time Act 210 became effective, Standard did not contest the program and, in fact, filed a plan as a self-insurer. However, after our 1975 amendment extending coverage for drug addiction and alcoholism treatment, Standard objected on the grounds that ERISA preempted the state from imposing employee benefits upon an employer. This objection was raised even though Standard's in-house coverage included the new benefits mandated by the amendment.

Three other employers — Goodyear, IBM and General Motors — raised similar objections. Only Standard, however, chose to contest our law in a legal action. Standard won in district court, and we are currently appealing the decision before the Ninth Circuit Court of Appeals. A major point raised in our answering brief is that the basis for our mandatory health insurance program is similar to the basis for our Workers' Compensation and Temporary Disability Insurance Laws, and thus not preempted by ERISA.

To conclude, in light of Hawaii's experience, I believe that any national health insurance plan should take into consideration the course that we have opted for. I am confident that standards we have set would meet any that a federal law would impose. As a means of encouraging other states to follow suit, or to adopt a true catastrophic plan such as Rhode Island's, I suggest that federal legislation provide support grants to at least cover administrative costs and any necessary premium supplementation expenses.

Finally, let me summarize the conditions that led to the successful adoption and implementation of Hawaii's Prepaid Health Care Act:

1. A political climate sympathetic to social needs.
2. Timeliness in terms of progressive improvements on the general body of social legislation already on the books.
3. A comprehensive study of a state's needs,

to arm proponents with the information necessary to justify the proposed legislation.

4. Open discussion involving all interested groups within the public.
5. A majority of employees already insured under voluntary plans or through government-employee programs. This last may be an element not very common to other jurisdictions, but I believe is an important aspect to be considered in any such deliberations. In our state, most employees were covered under plans offered by two major insurers in the state. Having a clear pattern to follow in prevailing benefits, it was easier to overcome resistance against extending similar benefits to all working men and women in Hawaii.

Catastrophic Medical Costs: Rhode Island's Response

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As the federal government continues to study and debate the issue of national health insurance, states have begun to assume the initiative by enacting their own health insurance programs. By 1978, seven jurisdictions had enacted laws whose purpose, with varying formats, is to provide comprehensive protection against the incidence of ill health.

With the passage of these state health insurance plans, some important issues are being addressed. For example, is this a clear signal to Washington that the states do not want to lose local control over the health care financing system? We believe this to be the case, at least in part in Rhode Island, and suspect the same to be true in other states.

Before describing Rhode Island's catastrophic health insurance program, I think it is useful to provide some background on the Nation's smallest state. In 1976, Rhode Island's total health expenditures reached \$667 million, an increase of 13.3 percent from 1975 expenditures. Almost three-fourths of all personal health care expenditures in Rhode Island were financed through public and private third-party payers in 1976. Moreover, only an estimated 4.7 percent of state residents had no public or private third-party coverage of health care costs in 1976, compared to a nationwide estimate of 12 percent. Rhode Island's estimated population in 1976 was 927,000, with a median family income of \$9,737.

Rhode Island's Catastrophic Health Insurance Plan, more commonly known as the CHIP Act, was enacted in April 1974 and became operational on January 1, 1975. Overall responsibility for CHIP is assigned to the Director of the State Department of Health, who reports directly to the governor. The Chief of the Division of Health Insurance is assigned all CHIP administrative duties. These include: monitoring program components assigned to other agencies (e.g., Department of Business Regulation); determining eligibility; developing and implementing policy, rules and regulations; auditing insurers' CHIP claim administration programs; providing appeal procedures; and certifying and monitoring health maintenance organizations (HMOs). The Department of Business Regulation oversees CHIP expenditures and program performance in areas such as minimum standards for health insurers, certification of qualified health insurance plans, and approval of rates.

Residents initially enter the CHIP system when they apply to the Department of Health for CHIP benefits. A review of the applicant's private health insurance coverage is undertaken first, since eligibility is contingent upon the applicant's type of insurance plan. The law defines a "qualified plan," and the greater the similarity between an applicant's policy and a qualified plan, the lower the deductible will be in order for the applicant to qualify for CHIP.

Fiscal intermediaries are utilized extensively for CHIP administration. Blue Cross of

Rhode Island pays CHIP claims for applicants who are Blue Cross subscribers, have no health insurance, are members of an HMO, or are Medicare beneficiaries (Title XVIII). Metropolitan Life is the intermediary for individuals with commercial health insurance policies. On a monthly basis, these intermediaries bill the Department of Health for the costs of claims plus administrative costs, the latter being determined as a percentage of the month's total paid claims. The administrative rate is subject to review and adjustment on an annual basis.

CHIP requires all employers of one or more employees in the state to provide a "dual choice" to their employees if they currently participate in a group insurance program. Employers must offer the choice of the current group insurance plan or an HMO membership — if a qualified HMO's service area encompasses the employees' place of residence. The HMO dual choice provisions of CHIP are viewed as meeting one of the law's primary goals: to ensure that each person in the state has access to available diagnostic, curative and rehabilitative health services. Prior to CHIP, employers rejected approaches from HMOs to solicit their employees. As a result, the entire HMO movement in the state was seriously hindered from expanding, or even maintaining, enrollment. This dual choice provision of the law has produced significant and immediate results for HMOs. In fact, a new HMO is in the planning stages in Rhode Island.

Eligibility for acceptance in the Rhode Island program is delineated primarily through the criteria enumerated in the CHIP legislation and regulations. CHIP eligibility is essentially contingent upon just two elements: residency and a deductible. Applicants, who are normally heads of a household, must be a permanent resident of the state for at least three months. (An applicant cannot have moved to Rhode Island primarily to become eligible for CHIP.) In addition, an applicant's out-of-pocket family medical expenses must exceed a CHIP deductible, specified in the law, after

all payments have been made by the applicant's private health insurance plan.

There are six levels of CHIP deductibles that may be applied to applicants. They are based on the type and the quality of the individual's private health insurance plan. As the quality — that is, the extent and comprehensiveness — of a person's health insurance coverage goes up, the amount of the CHIP deductible goes down. The lowest deductible category applies when a resident has what the law defines as a "qualified plan." This qualified plan is a combination of benefits, such as those provided by either Blue Cross or a commercial insurer, that must include the following: semiprivate hospital room coverage for at least 120 days; a medical/surgical plan providing coverage for usual and customary physician charges; and a major medical program providing at least \$10,000 in supplemental coverage.

In short, CHIP provides an incentive for families to subscribe to an insurance plan that offers deeper, more comprehensive coverage. The CHIP "rewards" for families with better insurance coverage is a smaller out-of-pocket deductible that must be spent prior to CHIP eligibility.

To elaborate further, a person who has a private health insurance plan that meets the "qualified plan" criteria must exceed a deductible of \$500 or 10 percent of their allowable income, whichever is greater. Persons with less coverage than that provided by a qualified plan will have to meet a larger deductible. A person with no health insurance must meet the greater of either a CHIP deductible of \$5,000 or 50 percent of their allowable income. (Allowable income is defined as the adjusted gross family income less dependents' allowances as determined by the IRS.)

CHIP has been designed as a "last payer" program. In other words, all other resources available to the applicant must be utilized before CHIP would consider payment. CHIP also is the secondary payer to other public programs such as workman's compensation, vocational rehabilitation, Medicare, and

Medicaid.

The benefits provided to those persons found eligible for CHIP are essentially the same as those described in the law and through specific departmental regulations as the components of a qualified plan. CHIP pays 100 percent of the usual and customary costs of those allowable costs over and above any other health benefits available to the applicant.

Coverage in several specialty areas was added by regulation to those benefits already provided directly by the law. For example, a qualified plan would pay for the Medicare deductibles and coinsurance for those persons on Medicare. Neither Medicare nor a qualified plan provides coverage for prescription drugs. Since this is one of the most costly items to the consumer, and largely unreimbursed by third parties, the CHIP regulations allowed for coverage of this type of expense. On the other hand, mental health benefits are currently under review by the Department, since 27 percent of CHIP benefits in fiscal year 1978 went for these services. Currently, CHIP allows for full coverage for patients in public or private mental hospitals and 50 percent reimbursement for outpatient psychiatric care.

That's basically the program: let's look at some problems which should be highlighted and finish with some of the program experience data.

Claim cost control is exercised over virtually all areas of benefit coverage, including prescription drugs and medical/surgical supplies and equipment, through the use of usual and customary fee profiles. Historically, psychiatric benefits have proven to be the most difficult to control. Selected cases, especially for out-of-state private facilities, have been referred to the psychiatric peer review committee for examination. Committee results have been a disappointment as a method for substantially reducing utilization and related costs, since outcomes of psychiatric care are extremely difficult to measure.

Migration of individuals to states that do offer more extensive social welfare benefits is

always a potential problem, as with any public program such as unemployment compensation and Medicaid. Although the Rhode Island program has only a three-month residency requirement, CHIP is designed to function as a "super" major medical plan with a good base of private health insurance protection. Thus, it would not seem worthwhile for a family to move to Rhode Island just to obtain CHIP coverage. If this does occur, however, and we are able to confirm it, we would be able to deny coverage under a relevant section in the law.

Now I would like to highlight some significant data for fiscal year ending June 30, 1978. A total of \$1.5 million was paid that year for claims under CHIP, an increase of 61 percent over the previous year. Eligible families totalled 396, with a total of 921 family members covered. The average CHIP deductible was \$1,402 and the average CHIP claim expenditure per family was \$3,883. Of the total number of eligible families, 32 percent had qualified coverage with Medicare, 24 percent had qualified coverage with Blue Cross/Blue Shield Plans, and 6 percent had no coverage. The leading three diagnoses reported by family unit were — in order of frequency — mental disorders, diseases of the circulatory systems, and malignant neoplasms.

Some of the basic lessons to be learned from a state-administered program such as CHIP include the following:

1. Psychiatric disorders will prove to be very costly and difficult to measure and control.
2. The use of fiscal intermediaries has been cost-effective, and limited the need to create yet another state bureaucracy. (We have a total of three additional persons at the Department of Health.)
3. The size of our program, about \$2 million, has had very little impact on the health costs of the state, but claims are continuing to increase in a straight-line curve upward in proportion to the increase in the number of families covered.
4. Program publicity is best directed toward

the provider network. The best referrals are now coming from hospitals, other state and local agencies, doctors, and nursing homes, in that order.

5. Medical review committees must review cases, particularly in view of the fact that — as with any state program — an applicant has the right to appeal adverse decisions all the way through the Superior Court system.
6. A uniform data reporting system should be established as soon as possible in order to provide for effective program evaluation from the onset.
7. The role of a CHIP-type plan should be clearly delineated in relation to a state Medicaid program; additionally, the characteristics of those persons falling through the gaps of both programs should be identified.
8. The program should be designed to react to the passage of a national health insurance plan. CHIP would pay only those expenses not covered by a national health program, thereby maintaining its role as a secondary payer to the very end, if necessary.
9. The program should structure eligibility deductibles or thresholds in such a way as to discourage a family from dropping its private insurance coverage, or decreasing its coverage, while at the same time advocating that insurance plans upgrade their existing policy coverage.

Expansion of CHIP coverage to those persons who may fall through the gaps, such as the working poor, should probably be extended first to those who have semiqualfied plans, prior to making CHIP available to others who have no coverage. This would be in keeping with the intent of the law, which is to help the average working person. The average working person, however, is becoming increasingly difficult to define. There are many average working persons who, for various reasons, are unable to afford qualified health insurance plans. These persons, rather than the uninsured, perhaps should be the next

target group for any restructuring of eligibility.

The success of CHIP depends on many factors, the chief of which is the absolute necessity for cooperation among state government, insurers, and providers. Because Rhode Island already had a good Medicaid program, CHIP was initially conceived as a “working person’s program.” It was designed with incentives for persons to purchase good basic health insurance coverage as an important initial step in total catastrophic health insurance protection.

Our state was one of the first nationally to implement this new approach to health insurance coverage, and thereby ensure that no citizen would be forced to “spend down” or “abandon” his or her family to receive the kind of help that would reasonably be given to any neighbor or friend who has been struck by tragedy. The jury is still out on a final verdict regarding our endeavor.

**Rhode Island CHIP Program
Expenditures and Recipients**

Fiscal Years 1975-1978

	<u>FY 75</u>	<u>FY 76</u>	<u>FY 77</u>	<u>FY 78</u>
Total CHIP budget	\$1,500,000	980,568	1,362,489	1,426,852
Claim expenditures	\$ 197,946	682,532	1,095,937	1,537,761
Individual claim payments	132	360	404	1,925
Eligible families	58	133	173	396
Family members eligible for benefits	134	365	411	921
New applications	176	N/A	N/A	257
Average CHIP deductible	\$ N/A	N/A	1,372	1,402
Average CHIP claim expenditure per family	\$ 5,349	2,966	6,335	3,883
Average reportable family adjusted gross income	\$ N/A	N/A	N/A	6,893
Appeals	13	19	17	2
HMO applications approved	2	3	3	3
Requests for information processed	492	N/A	N/A	1,076
CHIP publicity visits/programs	30	32	44	26

**Rhode Island CHIP Program
Types of Insurance coverage by family**

<u>Insurance Plan</u>	<u>Total</u>	<u>% of Total</u>
No coverage	24	6%
Qualified Blue Cross/Blue Shield	97	24%
Semi-qualified Blue Cross/Blue Shield (no major medical)	6	2%
Qualified Medicare	128	32%
Semi-qualified Medicare (no supplement)	41	10%
Non-qualified: Blue Cross/Blue Shield; Medicare; Campus	40	10%
Qualified HMO	6	2%
Non-qualified HMO	0	0%
Qualified commercial	11	3%
Semi-qualified commercial	1	0%
Non-qualified commercial	42	11%
Total Non-Medicare	227	57%
Total Medicare	169	43%

Rhode Island CHIP Program
Primary diagnosis reported by family unit

	<u>Total</u>	<u>% of Total</u>
Mental disorders	71	18%
Diseases of the circulatory system	71	18%
Neoplasms	53	13%
Diseases of genitourinary system	41	10%
Diseases of nervous system and sense organs	21	5%
Accidents, poisonings, and violence	21	5%
Maternity	21	5%
Diseases of the musculoskeletal system and connective tissues	20	5%
Diseases of the digestive system	17	4%
Endocrine, nutritional, and metabolic diseases	11	3%
Diseases of the blood and blood forming organs	10	3%
Diseases of the respiratory system	10	3%
Symptoms and ill-defined conditions	9	2%
Complications of pregnancy	7	2%
Congenital anomalies	7	2%
Certain causes of perinatal morbidity and mortality	3	1%
Infective and parasitic diseases	2	0%
Diseases of the skin and subcutaneous	1	0%

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State innovations in health
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Editors' Note:

This publication is the result of a cooperative effort between the National Conference of State Legislatures (NCSL) and the Intergovernmental Health Policy Project at George Washington University. The National Conference of State Legislatures is the country's official representative of the nation's 7,500 state legislators and their staffs. NCSL's three main objectives are to improve the quality and effectiveness of state legislatures; to insure a strong state role in the federal decisionmaking process; and to foster interstate cooperation and communication. The Intergovernmental Health Policy Project is a research program funded by the Health Care Financing Administration to investigate the health laws and programs of the nation's state governments. In addition to research, the IHPP publishes a newsletter on state health developments and maintains a clearinghouse on state health legislation.

Due to fiscal and space limitations, not all the speeches given at the NCSL conference could be included in this volume. Similarly, most of the speeches herein have been edited to some degree in order to make this a more manageable publication.

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